State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

2. Date of Death

}	35001
	3. Time of Death
1	6:43 P M
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rthp oun	lace (State or Foreign try) /land
_	
10	0d. Inside City Limits
	1 □Yes 2X No
oun	try?
eric te, e	an Indian, etc.
ni†	te

Physician /Medical Examiner **Funeral** Director with the Maryland show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

1. Decedent's Name (First, Middle, Last)

Physician /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed burial-tran attending physician for use as the burian led by the a signed I icate has been significate has page 2 should b director, funeral After 1

Division of Vital Records, P.O. Box 68760,

24 hours after death Funeral Director: filled in by the the Hospital completely within 2

October 2009 Bostian Shirley Grace 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea Carroll Westminster Carroll Hospice Dove House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 7, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Bi Days Hours Months 1 □ M 2 🖾 F 1935 Ma 216-32-2783 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a, State Director Keymar MD Carroll 10g. Citizen of What C 10f. Zip Code 10e. Street and Number USA 21757 5767 Middleburg Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Am Black, Whi 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: W ≥ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) bank loan officer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rachel Irene Ogle Chester Theodore Zentz ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3322 Kump Station Rd. Taneytown, MD 21787 Rodney K. Bostian, Jr./son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 10/31/09 Thurmont, MD Blue Ridge Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of FacilityHartzler Funeral HOme atharine Union Bridge, MD 21791 6 E. Broadway Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sublura Hematomo disease or condition resulting in death) Due to (or as a consequence of): Rospirator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: $_{4\,\square\,\,\text{Nursing Home}}$ 5 \square Residence 6 \square Other (Specify LOSPICE 1∑XYes 2☐No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 XNo 2 XAccident 10/13/09 8:30 AM Fell from standing position 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5767 Middleburg Rd Keymar, MD Home cal 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) icense number 17 00 519 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rules Street Worth and 21157 16 31. Date filed (Month) State

Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 For State Registrar 35002 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death October 24, 2009 **Physician** William C. Bartels 4:55 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Manor Care Bethesda Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours September 21, 1923 New York 1 X M 2 □ F 86 087-16-3627 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f si traumatic event, It a Modical Examinar must be redified 1 ☐ Yes 2 X No Directo Maryland Montgomery Bethesda the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6049 Avon Drive 20814 United States death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 💢 No Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Specify. White ⋧ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Department of Energy Physicist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Τ. Flynn Julia Joseph Francis Bartels ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a 6049 Avon Drive, Bethesda, Maryland 20814 Mary T. Bartels / Wife other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o October 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate Of Heaven Cemetery Silver Spring, Maryland 28, 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature-of Funeral/Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Alzheimer's Disease Unknown disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that in list and sectors) Examiner Due to (or as a consequence of): the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 ☐ Other (specify) signed by the a P.0. 1 ☐ Yes 2 ☐ No 9 Unknown law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Dementia, Poor Intake, Adult Failure to Thrive cate has been si , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy perforn 2 X No 1 ☐ Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After 1 28b. Time of ospital or Atter.

24 hours after death.

•••al Director: After

••• the fur 28c 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) the and manner stated. ense number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) howder D43121 October 27, 2009 30. Name and address of person who completed cause of death Item 23a) (Type, Print) Nurul A. Chowdhury, M.D. 15216 Dino Drive, Burtonsville, Maryland 20866 31. Date filed (Month, Day, Year) State Registrar

			1 - State Amend Item	State of Maryland / Dep 23a per dr., g896	artment of Health and I 11/02/09dhb rtificate of Death	Mental Hygi Re	ene 2009	35003
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		LULA		BUTTS	OCTOBER	13 200	9 1:11 PM
	Examir	er	4a. Facility Name (If not institution, give si NORTHWEST HOSPITA		4b. City, Town, or Location of Death RANDALLSTOWN	h	4c. County of Dea	
	Funeral Director		21-10-1011	M 2 Tr. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day,	Year) 9. Bir C.	thplace (State or Foreign ountry)
	Aarylend f ehow	or	Usual Residence of Decedent 10a. State 10b. County Battin	10c. City, Town or L	ocation 21 sterstown			10d. Inside City Limils
	with the A 3e or 28e-	Direc	100. Street and Number 12056, Tarragon	Rd.	101. Zip Code 21136	10	g. Citizen of What C	ountry?
920	s 1 end 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Item 27 ie marked other then "netural", or iteme 23s or 28s-f show other treumatic event, the Medical Examinations in cities at	by Funeral		2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi Specify:	
21215-0036	d within 72 hor piene. r then "netural the Medical I	Completed	15. Decedenl's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) (Give	edent's Usual Occupation a kind of work done during most of work DD NDT use retired) Workley	rking	6b. Kind of Business Departmen Service	Andustry + of Social
Maryland 2	ould be filed Mental Hygi arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) Howard Reason			me (First, Middle, M. IMM		
	1 end 2 should Heelth and Men em 27 ie marke ther treumatic:		19a. Informant's Name/Relationship (Typ) Thomay Coleman	e. Print 19b. Mail - daughter 1008	ing Address (Street and Number or Au Bent Tree Law	ural Route Number,	City or Town, State, Columbi	
Baltimore,	Pege nent o ant: If ary or		20a. Method of Ďisposition 1 ☐ Burial 2 ☐ Ĉremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disp camatery, cre Metro	cosition (Name of amatory or other place) Crematory 10/2	Date 2	Catonsville	Town, State Maryland
Balt	permit. Departr Imports eny inju		21. Signature of Funeral Service License	ankh 3	22. Name and Address of Facility 12- 3512 Frederick t	fer Funer	al Home	laryland
>	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do not er a cause on each line. Heart Failure Due to (or as a consequence of):		c or respiratory arre	st,	Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury	Due to (or as a consequence of):				
,8260,	cete be executed physicien end the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
.O. Box 68	ne death certifi the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	olivery Day Year
<u>α</u>	es thet Igned b be deta	þ	Part II. Other significant conditions cont Mitral Regurgitat		underlying cause given in Part I.			o the cause of death?
Il Records,	The law ete has b page 2 st	Completed				24a. Was ar autopsy perform 1 Yes 2	ned? death?	utopsy findings available completion of cause of
Vital	Physician: This certificer	Be	25. Was case referred to medical examiner?	ospital:	Other	ath Check only one	al .	
of	dlng After fune	ition: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 2 ■ EP/Outpatie 28b. Time Injury		10me 5 ☐ Reside 28d. Describe ho	nce 6 □Other (Spe w injury occurred	ecify)
Division	5 th 2	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, elc. (Specify)		28f. Location (Str City or Town	reet and Number or R , State)	lural Route Number,
	To the Hospital or Attentwithin 24 hours after deating the Funeral Director; completely filled in by the	edicai	29a. Certifier (Check only one) Certifier (Medical Examin	On the basis of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	and due to the eaurred at the time, da	uee(s) and manner a ite and place, and du	e to the cause(s)
	To t To t	Σ	29b. Signature applying of dentiliar	luo_	29c. License number D0060293		Od. Date signed (Mon	6.3
(4)		30. Name and addres of person who cor	npleted cause of death (Item 23a) (Type	D0060293 D0060293 DOT ROAD RANDA		MD 2:	
	Sta	te	MURTUZA AUMED, 31. Date filed (Month, Day, Year)	M. D. 5401 OLD Co.	URI KOAD KANDA	ill stown	MD 2113	3
	Registr		NOV U 2 ZUUS	32. Regislrar's Signature				

State of Maryland / Department of Health and Mental Hygiene 35004 Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** BRIEGER 11:02 AM 2009 Harol 10 29 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, give street and number) Examiner Nursing OA BaltIMORE CATONSVIlle a Hours Min. B. Date of Birth (Month, Day, Year)

JULY 16, 1913 9. Birthplace (State or Foreign 7. Age (th yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Months 1\\ M 2□ F Days 78 Yrs. MARYLAND 215-28-6572 Director Usuel Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits show 1 X Yes 2 □ No Director MD N/A BALTIMORE 28a-f trsumetic event, the Medical Examiner must be notified 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code ò Items 23a 737 WEST HILLS PARKWAY 21229 U.S.A. Funerai filed within 72 hours efter deeth 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 M Yes 2 □ No If Yes, Give Year or Dates: 1951 – 53 1 Never Married 2 Married 5 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE Š 3 Widowed 4 Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry tel Hygiane. College (1-4or 5+) TECHNICIAN HEATING CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h end Mantel I Pagas 1 end 2 should be KURT BRIEGER LINA KRACHT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21163 19a. Informant's Name/Relationship (Type, Print) Depertment of Heelth ei important: If item 27 is any injury or other trsu once. MARGARET BRATTON/COMPANION 10801 ENFIELD DR., APT. 410, WOODSTOCK, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 10/30/09 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22 Name and Address of Eaching LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTO., MD. 21231 Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** 5 years /Medical Immediate Ceuse (Final disease or condition resulting in death) asoular diseas Examiner Due to (or as a consequence of) by Physician/Medical Examiner ed by the attanding physician and detached for usa as the burial-transit Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 20 No 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? Failure to thrive 24a. Was an autopsy performed? Be Completed 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No this certificate 25. Was cese referred to medical 26. Plece of Death (Check only one) Other: 1 Ves 2 No 1 🗆 Inpatient Certification: To 2 ER/Outpatient 3□ DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftar Injun 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation tha Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ aftar 4 Homicide within 24 hours aftar To the Funeral Direcomplatally filled in b ō Hospital 29a. Certifie 1🗹 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) and manner as stated. edicai (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R084191 LIM 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) HITEFORD (RNP 6095 MARSHALEEDR; ELKRIDGE MD 1 31. Date filed (Month, Day, Year) Registrer's Signature State 2 2009 Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

			1 - State Registrar				Ce	rtificate of	Death		Reg. No.	2009	35005
			1. Decedent's Name	e (First, Middle, La	st)					2. Date of D		Voor	3. Time of Death
	Physici /Medi		Thelma D	 Bailey 						Octob	Day Se C	24,2009	2150 M
	Examir		4a. Facility Name (/	f not institution, giv	e street and nun	n <i>ber)</i>		4b. City, Town,	or Location of Deatl	_	4c.	County of Death	
	6		Salisbuci	Rehabi	litation	aNurs	nacto	Sal	lisburg	_	- (Wicon	
	Funeral		5. Social Security N	unlinber 6.8	Sex □M 2KPF	7. Age (In yrs. I	ast d irthday, Yrs.	If Under 1 Year Months Days		8. Date of Bi (Month, D Jan 13	irth (ay, Year) 196	Cou	place (State or Foreign ntry)
	Director		225-15-1 Usual Residence of	084		47	115.			Jan 13	, 196	oz Virg	gínia
	land Dw		10a. State	10b. County		10c. City	y, Town or Lo	ocation				1	10d. Inside City Limits
	with the Maryland a or 28a-f show	호	MD	Wicomic	0	Sa	lisbur	У					1 □ Yes 21 No
	the 28a	rec	10e. Street and Nur					10f. Zip Code			10g. Cit	izen of What Cou	ntry?
	death with the Maryland ims 23a or 28a-f show	Funeral Director	423 Jeffe	erson Str	eet			21801			U	SA	
	ours after death w al", or Items 23a Extended to a count	ner	11. Marital Status		12. Was Dece Armed For	dent Ever in U.	S. 13.	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or N	0-	14. Race - Ameri	
70	or Ite	F	1 🖺 Never Marri	ed 2 Married	1 Tes	2 No un		1 ☐ Yes 2 X No		O Hicari, etc.)		Black, White,	_
900	ural",	d by	3 Widowed		Year or Da	ates:		10100 22100	ороспу.			Specify: D16	
15-6	filed within 72 hours after Hygiene. other than "natural", or Ite ent, he Medical Exercit	Completed	(Spec	15. Decedent's Ed cify only highest gra	ducation ade completed)		16a. Dece (Give	dent's Usual Occu kind of work done	upation e during most of wor ed)	king	16b. Ki	ind of Business/In	dustry
782	withir ene. than	Ę	Elementary/Seco	ndary (0-12)	College (1	-4or 5+)		disabled	ea)			none	
d 2	filed Hygi ther	ပ္	17. Father's Name	First, Middle, Last				<u>IISAUIEU</u>	18. Mother's Nan	ne (First, Middle	. Maiden		nk.
Ima Maryland	d be ental ked o	To Be									,		
Ima	should and Mer s marke	-	19a. Informant's Na	ame/Relationship (Type. Print)		19b. Maili	ng Address (Stree	et and Number or Ru	ıral Route Numi	ber, City o	or Town, State, Zij	p Code)
E E	and 2 ealth a n 27 Is		Salisbury	Rehab &	Nursin	g	200 C	ivic Ave	nue; Sali	sbury,	Mary	land 218	04
ore,	of He of He item		20a. Method of Disp			20b. P		sition (Name of matory or other pla		Date		ocation - City or To	
T E	Pages nent of ant: If its ury or o		1 ☐ Burial 24 4 ☐ Ponation	Toremation 3 5	Removal from S y in sta	ate /		natory of other pro					
The Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, Inc. 100ce.		21. Signature of Ex	eral Service Lice	Nade/D	reckor	Š	2. Name and Addi	ress of Facility Comy Boar	d: 655	W. Ba	altimore	Street
Ш	6 2 5 G	0	Jun	4/1/	111	100	\bigcup B	altimore	, Marylan	d 21201			
			23a. Part 1. Enter the shock, or hea	ne dis p ase, or com rt failure. List only	plications that ca one cause on ea	aused the death	. Do not en	ter the mode of dy	ring, such as cardiad	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (disease or conditio	Final n	Me	las	fold	16	2000	Co	are		Clan
	/Medical Examiner		resulting in death)	•	Due to (or as a consequ	ence of):					/	/
		,	Sequentially list cor	nditions,	b	or as a consequ	and the same						
77	nsit	Ë	Sequentially list correction, leading to include Cause. Enter Unde Cause (Disease or that initiated events	rlying injury	See to (or as a consequ	with the oil)						
Ć.	exect n and ial-tra	Examiner	that initiated events resulting in death) L	ast	C. Due to (or as a consequ	ience of):						· · · · · · · · · · · · · · · · · · ·
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ca		•	d								
89	rtifica ng ph as th	Medical	15.55441.5									7.5%	5954
Box	eath cert attendin for use a		IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outo	come of pregna		☐ Ectopic pregnar	nev			23d. Date of deliv	·
О.	e dea he at ed fo	sici	in the past 12 1 ☐ Yes 2 ☐			ant at time of d		Other (specify)	· · · · · · · · · · · · · · · · · · ·			Month	Day Year
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Division of Vital Records,	Atte ectol by th	iţi	3 ☐ Suicide 4 ☐ Homidide	6 ☐ Could not be determined	28e. Place	of Injury - At ho	me, farm, sti	eet, factory, office		28f. Location	(Street an	d Number or Run	al Route Number,
i	tal or rs afte al Dir led in	Certification: To	4 El Hornicide		Dullull	ig, etc. (Specify	,			City or 10	wn, State	")	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s		29a. Certifier (Check only	1 ☐ Certifying Ph 2 ☐ Medical Exar	ysician: To the	best of my know	wledge, deat	h occurred at the	time, date and place	e, and due to the	e cause(s) and manner as	stated.
	thin 2 the 1 the 1	Medical	one)		and mann	er stated.							
	Z <u>≥ Z 8</u>	-	29b. Signature and	7	41/	//		250. Licen	se number	P	zau. Dai	te signed (Month,	Day, real)
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			30. Name and addre		ins, M.	-	20a) (Type,	ivic AL	1e. Sili	sburg	. M	RIG (FALL
	Sta	te	31. Date filed (Mont	h, Day, Year	32. Re	egistrar's Signat	We are	1010110	ا الله	2019	1/1/	U 0(10	,07
	Registr	ar	NOA	1 % COOR	Claura	P. 19	Parke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35006 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dctober 27,2009 Charles Bryant 8:34A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Towson Baltimore 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Days Months Hours Sept9,1953 Marwiland 213-62-2140 56 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Md. Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 803 South Ponca Street 21224 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 6th College (1-4 or 5+) Truck Driver Delivery Be 17. Father's Name (First, Middle, Last) (unk) (unk) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Delores Bryant (wife)</u> 803 South Ponca Street Baltimore, Md. Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory Baltimore,Maryland 4 Donation 5 Other (Specify) 28.2009 21. Signature of Funeral Ser 22. Name and Address of Facility Kaczorowski Funeral Home, P.A Avenue Baltimore, 201 <u>Dundalk</u> Md.21222 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Wonic disease or condition resulting in death) 065thethe Medical ue to (or as a consequence of) Examine Sequentially list conditions Examiner Due to for se a noneequence of cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. signed by the attending physician and I be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal deal Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 autopsy performed Yes 2 death? 2 🗆 No 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 🗌 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence To the Hospital or Auerica... within 24 hours after death.

To the Funeral Director: After thi funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural P 5 Pending work Accident 1 Tes 2 🔲 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) October 27 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST TOWSIN MD AARIN 6701 CHARVES M Charles 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #25 per ME 8897 1179/09 TT
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 35007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10-25-2009 Day **Physician** 2358 Elizabeth D. Cary /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford Birthplace (State or Foreign Country) . Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 X F Hours Months Days 82 157-16-8193 Director NJ 11-30-1926 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, If a live field at 1 ☐ Yes 2√☐ No Director NJ Mercer Hamilton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 219 Barricklo St 08610 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ould be filed within Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aid Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Gazick Theresa (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health and item 27 is n Pages 1 and 2 siment of Health an 1553 Bentley Circle Bel Air, MD 21015 Stanley B. Cary, Jr (Son) Baltimore, Date 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department St. Mary's Cem. 10-31-2009 Hamilton, NJ 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc 610 W. Macphail Rd BEl Air, MD 21014 23a. Part 1. Enter the disease, or complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Intracerebial /Medical Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Sequentially list conditions, if any, leading to immediate cause. Emer orriderlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of). P.O. Box 68760 the attending physician The law requires that the death certificate be Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 1 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? NSOO502 287 Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed 1 □Yes 2 🖽 No Hospital or Attending Physician: 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) examiner: 1 XYes 2 100 Hospital: 1 ☑ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D63420 10 V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zubair Kharal, M. O. 500 Upper Chesapaye Dr. Bel Air, MD 21014

Date filed (Month, Day, Year)

NOV 02 2009 22. Registrar's Signature D. Aparts Dr. Bel Air, MD 21014 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

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CARY

ric J. Cromwell	1-	Starte State	te of Maryland / D	epartment of Certificate of	Health and	Mental Hy		No. 200	9 3500
Physician		egistrar . Decedent's Name (First, Middle,		,	Dodan		Reg. 2. Date of Death		3. Time of Death
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		University Hospital	give street and number/	_ [Baltimore	occupit of Bods.		NA	
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ours after atural" xaming	<u>5</u>	15. Decedent's Education (Specif	or Dates:	ed) 16a. Decedent	's Usual Occupationst of working life. E	n (Give kind of v		6b. Kin of Business/	Industry
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Baltimore permit. Pages 1 & Department of H Important: If it injury or other t		4 Donation 5 Other Spe			ame and Address of		-	Limore, m	- FunedHSP
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of Vital Recting Physician: The Land After this certificate funeral director, page	2	1 Yes 2 No 27. Manner of Death 1 Natural 5 Death	28a. Date of Injury (Month, Day Year) Jun 11, 2009	28b. Time of Ir 2145 hrs	njury 28c. Injury	at Work?		w injury occurred	-
Division of Vital Records, tat or Attending Physician: The law requirers after death. al Director: After this certificate has been and office the function to page 2 should the fact that the Process.	Certification:	2 Accident Investi	igation	- At home, farm, stree		es 2 V No uilding, etc.	28f. Location (Str		ural Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director completely filled in by the		4 Homicide determ	nined (Specify) Local		and at the time, dat	o and place and		th Street, Baltimore	
To the Hospital within 24 hours To the Funeral completely filled	ισ.	Check only Certifying Phy	/sician: To the best of my kn niner:On the basis of examina and manner stated.	ation and/or investigat	ion, in my opinion,	death occurred	at the time, date ar	nd place, and due to t	he cause(s)
	Ž	29b. Signature and title of certifier	11/1	4	29c. License O.C.M			29d. Date signed (Mo October 30, 200	
12 V		30. Name and address of person w Zabiullah Ali, M.D. A	who completed cause of do the ssistant Medical Exam		n Street, Baltir	more, MD 21	1201		
Sta Registra	-	31. Date filed (Month, Day, Year)	32. Resistrar's S		20				
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			For State Registrar	State of Maryl	and / Depa <i>Cei</i>	artment of H <i>tificate of D</i>	ealth and N <i>eath</i>	ا Mental Hy	giene Reg. No.	009	35009
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	Funeral Director		5. Social Security Number 6. Sec. 1	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt 10-20-2	h 2009		place (State or Foreign
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	with the	eral D	10e. Street and Number 2348 Kateland Ct			10f. Zip Code 21009			10g. Citizen o	of What Cou	ntry?
9800	is filed within 72 hours after death with the Maryland tal Hyglene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates.		Nas Decedent of His f Yes, specify Cubar 1 ☐ Yes 2X No	Specify:	ecify Yes or No- Rican, etc.)		ace - Ameri lack, White, ify: Wh	etc.
Maryland 21215-0036	vithin 72 ho iene. r than "nai the Medica	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)		(Give	dent's Usual Occupa kind of work done di O NOT use retired)		king	16b. Kind of	Business Ir	dustry
and 2	be filed w lental Hygi rked othe	To Be	17. Father's Name (First, Middle, Last) Antonio Castellan	0			18. Mother's Nam		Maiden Surna	me)	
, Mary	id 2 should be file balth and Mental I n 27 is marked c er traumatic eve		19a. Informant's Name/Relationship (Type Antonio Castellano			ng Address (Street a Kateland					Code)
Baltimore,	permit. Page 1 and 2 should be for Department of Health and Menta Important: If item 27 is marked any injury or other traumatic enone.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		esition (Name of matory or other place Mem. Gar.) !	Date 0-2009	20c. Location	•	· —
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	างรเต่อก Medical	36	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)		ASCULAR			or respiratory arr	rest,		Approximate Interval Between Onset and Death
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Ital	sician: certific rector,	æ	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:		Otho	ce of Death (Chec	k only one)		V V V V	
of <	ng Physter this neral di	te: To	27. Manner of Death	1 Inpatient 2 28a. Date of injury (Month, Day, Year	2 ER/Outpatier 28b. Time of injury	nt 3 🗆 DOA J	4 ☐ Nursing Heat	ome 5 Residence 128d. Describe h			y)
vision	or Attendie fter death. irector: Af n by the fu	Certificate:	Natural 5 Pending Accident Investigation Suicide 6 Could not be Homicide determined	28e. Place of Injury - A building, etc. (Spe	At home, farm, str	M 1 🗆 '	Yes 2 □ No	28f. Location (S		nber or Rura	al Route Number,
۵	Hospital of the same of the sa	Medical C		cian: To the best of my kr er: On the basis of examin							
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	Ø v Star	e	MARIL VN BENNE] 31. Date filed (Month, Day, Year)	32. Redistrar's Si	7601 09	SLER DRI	VE TOW	ISON. ME	RYLAN	D 21;	-04
	Registra		NOV 0 2 200	9 Den	1. A.	ake					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 2009 Gladvs Mae Jenkins Coles 12:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Luth. Village Hlth. Care Ctr. Westminster Carroll If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🔀 F 25, Director 213-20-2669 85 1923 Maryland Nov. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County fshow a or 28a-f show be notified at 1 ☐ Yes 2 X No Director Westminster Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 1536 Brehm Road permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must bonce. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: <u>\$</u> White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 administrative assistant American Red Cross 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Schley Jenkins Sr. Muriel M. Franklin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie C. Scharon/daughter 1536 Brehm Rd. Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Sams Creek Cemetery 11/2/2009 Dennings, MD 21. Signature of Funderal Service Licens 22. Name and Address of Facility Hartzler Funeral Home 310 Church St., New Windsor, MD 21776 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. iongestive Immediate Cause (Final HEART **Physician** 24501 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 104em hibrillahow if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine death certificate be executed burial-transi that initiated events and resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has 1∐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 1 | Yes 2 | No 2 ER/Outpatient 3 DOA 4 ■ Nursing Home 5 □ Residence 6 □ Other (Specify) P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Mannes of Death Certification: 1 Natural Injury 5 ☐ Pending 1 □ Yes 2 □ No investigation 2 ☐ Accident

Box 68760. P.0. Division or Vital Records, death. To the Hospital within 24 hours a

To the Funeral I

6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier Collus In m Mamao

29c. License number

29d. Date signed (Month, Day, Year)

031660

10/29/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ittems k. Carring mo STONER AVENUE 291

and manner stated

CUESTMINSTER manyloud 21757

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			_ For		State of M	arylan	d/D	epartme	ent of F	Health	and M	ental Hy	gien	е	
			1 - State Registrar				(Certifica	ate of	Death			Reg. N	2009	3501
	Physici /Medic		1. Decedent's Name	e (First, Middle, L		ohn	Cav	allo				2. Date of De Month Octobe	ath D	27, 2009	3. Time of Death
1	Examir		4a. Facility Name (/	f not institution, g	ive street and number)			4b. Cit	ty, Town, o	r Location	of Death		40	c. County of Deat	h
				n Hospit						resda	157			Montgome	
	Funeral Director		5. Social Security N 234-32-1	647	. 50	ge (In yrs. i		rs. If Unc Month	der 1 Year Is Days	If Under Hours	Min.	8. Date of Bir (Month, Da January	th 25,	1923 West	hplace (State or Foreig untry) t Virginia
	fand ow		Usual Residence of 10a. State	10b. County		10c. Cit	y, Town	or Location							10d. Inside City Limits
	with the Maryland a or 28a-f show be notified at	tor	Maryland	Montgon	nerv		Roc	kville							1X Yes 2□No
	h the	jrec	10e. Street and Nur	mber					Zip Code				10g. C	itizen of What Co	untry?
	23a c	<u>s</u>	2997 G1	enora La	ine				2	20850			Ur	nited Sta	ates
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the "sed call Exam" har must be notified at	by Funeral Directo	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	ed 2 X Married 4 Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 ☐ If Yes, Give Year or Dates:	No	s. III		cedent of Hoecify Cubi	Hispanic Or an, Mexica Specify		cify Yes or No Rican, etc.))-	14. Race - Ame Black, White Specify: Wh	rican Indian, e, etc. nite
5-0	72 hc natur	etec	(Spec	15. Decedent's E	Education rade completed)		16a. [Decedent's Us Give kind of N	sual Occup	ation during mos	st of workin	na	16b. l	Kind of Business/l	Industry
121	es 1 and 2 should be filed within 72 ho of Health and Mental Hyglene. I filem 27 is marked other than "natur r other traumatic event, the Medical	Completed	Elementary/Seco		College (1-4or 5	5+)	١.	Give kind of v life. DO NOT counta		d)			A1	itomotive	2
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Baltimore, Maryland 21215-0036	Pag nent ant: I		4 ☐ Donation	Cremation 3 5 Other (Spec	Removal from State			Disposition (A crematory of Heaven C	emeter	у	2009		Sil		ng, Maryl <i>a</i> nd
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	/Medical Examiner		resulting in death)	•	Due to (or as										N5 4-1
		ē	Sequentially list cou	nditions, mediate	b. Valvu			unctio	n						Months
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68760,	ficate I physics the b	edical			d										
10/44/07(S, P.O. Box 6	eath certi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 □ 9 □ Unknown	months? ☐No	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	I death	3 ☐ Ectopio 5 ☐ Other		;y				23d. Date of del Month	ivery Day Year
rds, P	w requires that the d been signed by the should be detached	δ	Part II. Other signif	icant conditions	contributing to death b	out not resu	ulting in t	the underlying	g cause giv	en in Part	l.	23e. Did 1			the cause of death?
- Rec	aw as t	Completed										24a. Was auto perfo 1 □Yes		24b. Were au prior to death? to 1 □ Yes	topsy findings available completion of cause of
<u>₹</u>	Physician: r this certificaral director, p	Be	25. Was case reference examiner?		Hospital:				Oth	or:		(Check only o			
	Phys r this ral dir	5.	1 ☐ Yes 2 🔀 27. Manner of Deat		1 X Inpati		ER/Outp	natient 3 me of		4 🗆 19		ne 5 Resi		6 ☐Other (Spec	cify)
מ ה	Attending r death. ector: After by the fune	tion	1 Natural 2 □ Accident	5 ☐ Pending investigation	(Month, Da	y, Year)		ury M	28c. Injui Wor 1 🗆	k? Yes 2 □		.ou. Dooonbo	rion inj	ary occurred	
1 =	je ∰ e	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine		ury - At ho c. (Specif	ome, farn	n, street, facto	ory, office		2	8f. Location (City or To	Street a wn, Sta	and Number or Ru te)	ıral Route Number,
الم	the Hospital nin 24 hours a the Funeral I npletely filled	Medical	29a. Certifier (Check only one)	1 X Certifying F 2 Medical Exa	Physician: To the best miner: On the basis of and manner st	of examina	wledge, ition and	death occurre or investigati	ed at the ti	me, date a opinion, de	nd place, a ath occurre	and due to the ed at the time,	cause date a	(s) and manner as nd place, and due	s stated. to the cause(s)
12.	To the within To the Comp	Me	29b. Signature and	title of certifier	MA	UNDO	SARM		29c. Licens				29d. D	ate signed (Monti	h, Day, Year)
			VI	1	Mes		/	4.D.	663	95			0ct	ober 31,	2009
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			Mauro Sa 31. Date filed (Mon		M.D. 860			orgeto	wn Ro	ad, I	Bethe:	sda, Ma	ary1	and 2081	. 4
	Sta Registr		ST. Date filed (MOTI	NOV 022				hard	A						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 35012 Certificate of Death 1. Decedent's Name (First, Middle, Last) October 29, 2009 Physician Czyzewski 5:02 P.M John /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Nursing Home Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 8. Date of Birth
(Month Day, Year)
July 14, 1931 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 213-28-3036 Ohio 78 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Md. Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 513 South Bradford Street 21224 U.S.A. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printer Printing /th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental H, Important: If Item 27 ia marked oth any Injury or other traumatte event ance. Be Frances Fastin Czyzwiski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7319 Hughes Avenue Baltimore, Md. 21219 19a. Informant's Name/Relationship (Type. Print) Richard Czyzewski (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 31, 2009 22. Name and Address of Facility Kaczorowski Funeral Home, P.A. 21. Signature of Funeral Service Licensee Rolmad 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Vieningioma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-tran Box 68760 P.O.

Baltimore, Maryland 21215-0036

Division of Vital filled in by completely

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

accolinacolini Khem MD

October 30, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Saeeduddin Khan, M.D. 5601 Loch Raven Blvd. Baltimore, Md. 21239

State Registrar

29a, Certifier

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

		_	Sta	ate of Ma	aryland	/ Depar	tment of	K. Ensure A Health and f Death	Mental Hygi	ene _	egible.	05010
		for State Registrar				Cert	ificate o	f Death	Re	g. No. 2	2009	35013
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t. Pages 1 and 2 rtment of Health rtant: If Item 27 li ljury or other tra		1 💢 Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth	er (Specify)	al from State		JACOB		10/2	9/2009 FI	NKSE	BURG, MD	
permit. Pages 1 Department of Important: If Ite any Injury or ot once.		21. Signature of Funeral Ser	vice bicensed	ruge	2	890	Name and Add	TERSTOWN	L LEVINSO ROAD,PIKE	ON & SVIL	BROS., LE, MD	INC. 21208
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To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 4	yes, outcome Live birth Pregnant a Unknown	2 Fetal d	eath 3 🗆 8	Ectopic pregna Other <i>(specify)</i>			230	d. Date of deliv	ery Day Y ear
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Hospital 24 hours a Funeral I etely filled	ledical Ce	29a. Certifier (Check only one)	ical Examiner: 0	: To the best	f examinatio	edge, death on and/or inve	occurred at the estigation, in m	time, date and plac y opinion, death occ	ee, and due to the ca urred at the time, da	use(s) a	nd manner as lace, and due t	stated. to the cause(s)
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and the			Seasons Ho	spice	0	A == ((=	r 4 fe2 - 44 - 44 - 1	Randalls	If Under 24 Hrs.	O Data of Dia		Baltimor	hplace (State or Foreign
	Funeral Director		21.8-28-3630		Sex 7 1√2 M 2 □ F	. Age (In yrs. 76		Months Days	Hours Min.	8. Date of Bir (Month, Da		9. Birti	unity)
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	or 28	Director	10e. Street and Num	nber				10f. Zip Code			10g. Ci	tizen of What Co	untry?
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and	othe rent,	Bec	17. Father's Name (First, Middle, Las	t)		*		18. Mother's Nam		, Maiden	Surname)	
<u>a</u>	uld be Venta rrked	오	Henry M. Dy	yson					Roxie Fo	æst			
Mar)	2 sho and I is ma auma	1	19a. Informant's Na	me/Relationship	(Type. Print)		19b. Maili	ng Address (Street	and Number or Rui	ral Route Numb	er, City	or Town, State, 2	Zip Code)
e, e	and ealth m 27		Monica P. 1		e			L Schnaper D					
0	ges 1 t of H If ite or otl		20a. Method of Disp		Removal from St	0	emetery, crei	osition (Name of matory or other plac	e) :	Date		ocation - City or	Town, State
arrimo	t. Par ntmen ntant: njury		4 □ Donation	5 Other (Spec	ify)	Mood	dlawn Ca		11-3-(llawn, MD	
ğ	permit. Pages 1 and 2 should be filed w Department of health and Mental Hygie Important: If item 27 is marked other t any injury or other traumatic event, In		21. Signaure of Fur	neral Service Lice	M. U	elli		2. Name and Addres					Balto. Co.
			23a. Par 1. Enter th	ne disease, or cor	nplications that cau	ised the deat		ter the mode of dyin					Approximate Interval Between
,	Physician		Immediate Cause (I	Final		ima	Can	cer				1	Onset and Death
	/Medical Examiner		resulting in death)		Due to (or	as a cons							
	LXammer	<u>.</u>	Sequentially list con if any, leading to imr	nditions,	b	r as a consequ							
	nslt	nin	cause. Enter Under Cause (Disease or i that initiated events	rlvina	Due to (or	as a consequ	uerice oi).						
,	execting and ial-tra	Examiner	resulting in death) L	ast	CDue to (or	as a consequ	uence of):						
04/8	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical		•	d								
ğ	rtifica ng ph as th		IS SEMALE.								- 1	-	
X Q	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent		23c. If yes, outco	me of pregna th 2 Feta		☐ Ectopic pregnanc	v			23d. Date of del	*
7	e dea the at	Physician/M	in the past 12 t 1 ☐ Yes 2 ☐ 9 ☐ Unknown		4 ☐ Pregna 9 ☐ Unknov	nt at time of c	feath 5 [Other (specify)				Month	Day Year
7.	res that the de signed by the a l be detached t		Part II. Other signifi	icant conditions	contributing to dea	th but not resi	uiting in the u	Inderlying cause give	an in Part I	23e Did t	obacco	use contribute to	the cause of death?
ecords,	signe d be d	d by	v are in Gardi digitin	ioune conditions	contributing to dea	in but not rest	arang in the a	inderlying cause give	on in Faith.			□ No 3□ Pr	
Ö	v require been si should b	letec								24a. Was			topsy findings available
Ď Ľ	ding Physician: The law requir n. After this certificate has been s funeral director, page 2 should i	Completed								auto perfo	psy ormed?	prior to death?	completion of cause of
VItal	an: T tificat tor, pa		25. Was case refern	red to medical					26. Place of Deat	1 □Yes		1 □Yes	2 No
>	yslcii is cer direct	o Be	examiner? 1 ☐ Yes 2 🖼 I		Hospital:	patient 2 🗆	ER/Outpatie	nt 3 DOA Othe				6 Other (Spec	city Hochice
10 0	ng Ph ter th neral	T:UC	27. Manner of Death		28a. Date of		28b. Time o			28d. Describe			
SION	endir sath. or: Ai	atic	2 Accident	5 Pending investigation	on		,,		Yes 2□No				
Ĕ	or Att fter de Directa in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not l determined	28e. Place of building	f Injury - At ho , etc. <i>(Specif</i>	ome, farm, sti y)	reet, factory, office		28f. Location (City or To	Street al wn, State	nd Number or Ru e)	ıral Route Number,
5	spital		29a. Certifier	1 Certifying P	hysician: To the b	est of my kno	wledge, deal	th occurred at the tir	ne, date and place	, and due to the	cause(s	s) and manner as	s stated.
	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director. After this certified completely filled in by the funeral director, p.	Medical	(Check only one)	2 Medical Exa	miner: On the bas and manne	is of examina	ition and/or in	nvestigation, in my o	pinion, death occu	rred at the time,	date an	d place, and due	to the cause(s)
	6 ≥ ≤ 5	-	29b. Signature and t	() I Am I	1B	1,00		29c. Licens		,	290. Da	ate signed (Montl	1, Day, rear)
			30 Nama and adding	WWW.	- WI VIII	Of death (the	000\ (7	Drint)	127 31	/		C1 405Y	21 007
	18		Dr P	Globle	Buton	5401	O'UO	COUNT P	oad Rai	dallst	w	1 MD	29 2009
	Sta Registr	re.		Day, Year)	MARCH TO THE STATE OF THE STATE	istrar's Signa	B	and a					
	, , , , , , , , , , , , , , , , , , ,			UY UN -	- Justo		10						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 35015 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 11:25 P M 2009 Catherine I. DeBord /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. HOSPI BALTIMORE AGMES TAL N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Mapthe Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 X 230-30-0317 05/16/1929 80 Virginia Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shore Examiner must be notified at 1 ☐ Yes 2 X No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 2027 Grinnalds Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. White 2 3 Widowed 4 Divorced d other than "natural event, the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bertha Catron Edward Lee Asbury 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If item 27 is or other tra Mr. William B. DeBord (Husband) 2027 Grinnalds Avenue, Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veteran-Crownsville 11/5/2009 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. Þ ۷ 9 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final FIBROSIS PULMONARY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Exami physi ian and the turial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Ö 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, ģ PERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 2 No 1 ☐ Yes 2 NO Hospital or Attending Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ nours after death.

neral Director: After this
filled in by the funeral di ō 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours e Funeral 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 S. CATON AV BALTIMORE LAMICHHANE, DIMAN

State

Registrar

31. Date filed (Month, Day, Year

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08346 State of Maryland / Department of Health and Mental Hygiene Christian David Davella 2009 35016 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) Time of Death 2. Date of Death Physician/ Month Day October 27, 2009 2015 hrs Medical Examiner Christian David Davella 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Rosedale 1902 Summit Avenue 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Days Hours Min. Country) Maryland Months March 10,1972 Director 37 213-08-3028 $_{1}X_{M}$ Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Yes 2 X No White Marsh Md. Balto. death with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number IISA 21162 5505 Rogue Court 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 Never Married 2 Married Yes ē White hours after 4 XDivorced If Yes. Give Year Yes 2 X No specify: Specify: à 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 72 marked other than " Baltimore, MD 21215-0036 mit. Pages I and 2 should be filed within: partment of Health and Mental Hygiene portant: If item 27 is marked other than Construction Drywall Contractor 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sharon Owens æ Benjamin F. Davella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is n traumatic White Marsh, Md. 21162 5505 Rogue Court Sharon Davella Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 10-31-2009 Middle River. MD Holly Hills Donation 5 Other Specify: 22. Name and Address of Facility Schimune k Funeral Home 21. Signature of Funeral Service License Nottingham, Md. 21236 9705 Belair Rd. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a Part I. Frier the disease, o Physician Between Onset and failure. List only one cause on each line. Medical Death a Narcotic and alcohol intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED 23a,27,28a-f,permE, tending physicfan a XUNPENDED g897 11/23/09 TT The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year icate has been signed by the attending | page 2 should be detached for use as th Live birth 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 V Unknown leted 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy Compl this certificate has performed? death? Yes 2 1 V Yes No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other; Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 DOA Innatient 2 1 V Yes No 28d. Describe how injury occurred subject used drugs and 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Natural 1 Yes X No Fd 10/27/09 Fd 8:00 pm alcoho1 2 X Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1902 Summit Ave Rosedale, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide house determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificielly filled in by the funeral director,

30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year)

and manner stated.

ORIGINAL

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

October 28, 2009

Medical

State Registrar

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 35017 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** RICHARD 9:15 28 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON CARE RUXTON MANOR Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea)
December 21, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Year) Months Days Hours 1 M 2 □ F 202-20-5977 Yrs. 1929 Pennslyvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2√∑ No Director Pennslyvania Adams Littlestown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural" or insuran injury or other traumatic event. 17340 U.S.A. 85 S. Gala Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status 1 MYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify \$ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computer Computer Programming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edith Rohler Ι., Ε. Davis Rov ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 85 S. Gala, Littlestown, PA 17340 Cheryl Rhine/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Hilltop Service Corp. 10/30/2009 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 1050 York Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DISEASE **Physician** ORONARY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ALZHEIMERS DEMENTIA 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed 2 10 1 🗆 Yes 2 □ No 1 ☐ Yes ours after death.

eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To the within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 057722 UCTUBER 29 2009 M.O.

State Registrar

31. Date filed (Month, Day, Year)

1838 GREENE TREE ROAP # 300

82. Registrar's Signature

DHMH 17 Rev 1/2001

PILESVILLE MD 21208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEONAW RUMA COSON M.P.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Physician JOSEPH DEPEEL 12:47PM 10 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTEOMERY MONTEOMBLY GENERAL HOST ITAL OLNEY 8. Date of Birth (Month, Day, Year) March 13, 1978 Michigan 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 590-70-4407 31 Yrs. March Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ral", or items 23a or 28a-f show 1 X Yes 2 ☐ No Director Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20851 705 Wade Avenue United States Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No White <u>ک</u> Specify 3 Widowed 4 Divorced "natural", Completed traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Drywall Finisher Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be ment of Health and Mental William Joseph DePeel Marcia Folts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important; if item 27 Is
any injury or other trau Jessie R. DePeel / Wife 705 Wade Avenue, Rockville, Maryland 20851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 29 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 2009 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850–2805 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MELANOTA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 X No 3 Probably 4 Unknown 1 🔲 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 Who certificate 1 ☐ Yes Division of Vital 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1∐Yes 1 Inpatient 2XER/Outpatient 3 □ DOA Certification: To this 27. Manufer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Registrar

31. Date filed (Month Day Year)-

29b. Signature and title of certifier

ISABELLA MARTIRE Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRINCE PHILIP DE # 204 OLMY 20832

29c. License number

29d. Date signed (Month, Day, Year)

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Oc. + Day Year 08:00am 2009 30 4c. County of Death Memorial 9. Birthplace (State or Foreign Security Number Months Hours Days 1 □ M 2 💢 F 215-40-584 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ es 2 ☐ No timore 10g. Citizen of What Country? 10f. Zip Code exmere 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 □ Yes 2 100 Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 501 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden KNOWN nber or Rural Route Number, City or Town, State Zip Code) 19b. Mailing Address (Street and Nu Informant's Name/Relationship (Type. Print) SILICAN-OF exmere 20a. Method of Disposition 3 Removal from State 1 Burial 2
4 Donation Burial 2 Cremation 5 ☐ Other (Specify) Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. ng, such as cardiac or respiratory arrest Immediate Cause (Final antery Coronary di sease 2 years disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading L. Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse uence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 1 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed's 2 DNO 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 4 Natural 1 ☐ Yes 2 ☐ No

Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran P.O. 1 us certificate has been signed by director, page 2 should be detack Records, Vital this ō

Hospital or Attending

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Physician

/Medical

Examiner

funeral within 24 hours after deat To the Funeral Director:

Physician

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Funeral Director

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Certification: To

Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygleine. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 ehromany injury or other traumatic event, the Mental Market France 200.

5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide 4 Homicide

1 — Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

end manner stated. M.D

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D0067741 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

October, 30, 2009

Waliel State

29a, Certifier

(Check only one)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Union Memorial Hospital, Baltimore, MD 21218 Barbour 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			For State Registrar	State of Mar		epartificate Certificate			entai riyg R	eg. No.2	009	35020
40.	Physicia **/Medic		1. Decedent's Name (First, Middle, Last	EMER	SON	J			2. Date of Deal Month	th	Year	3. Time of Death 7.30 pm
	Examin		4a. Facility Name (If not institution, give			4b. City, TBalti	Town, or Locati	ion of Death		4c. Co	ounty of Death	
	Funeral		Caton Manor Nursin 5. Social Security Number 6. Se		(In yrs. last birth	day) If Under	1 Year If Un	nder 24 Hrs.	8. Date of Birth		9. Birth	place (State or Foreign
	Director		218-46-0885	_M 21€F	61 Y	S. Months	Days Hou	urs Min.	(Month, Day, April 21	i, 19	48 Mai	ryland
	and w		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town	or Location						10d. Inside City Limits
	Mary a-f sho	tor	MD Baltimor	е	Baltimo	re						1⊠Yes 2 No
	th with the 23a or 28 ist be not	al Director	10e. Street and Number 3030 Wilkens Avenu	e		10f. Zip 2122			1	0g. Citize USA	n of What Cou	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		13. Was Deced If Yes, spec 1 ☐ Yes 2			ecify Yes or No- Rican, etc.)		Black, White pecify: wh:	etc.
2 2	72 ho	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a. [Decedent's Usua Give kind of wor life. DO NOT us	al Occupation	most of worki	ng	16b. Kind	of Business/I	ndustry
121	within iene. than the	dmo	Elementary/Secondary (0-12)	College (1-4or 5+))	usewife				own	home	
and 2	12 should be filed w h and Mental Hygie 7 is marked other t traumatic event, th	Be	17. Father's Name (First, Middle, Last)	unk			18. M	other's Name	(First, Middle,	Maiden Su	ırname) un]	C
-	nd 2 shoul alth and Me 27 is mark r traumati	<u>م</u>	19a. Informant's Name/Relationship (7) Yoko Stevens/socia		Cat	Mailing Address on Mano timore,	or Nurs:	ing Ho	ne: 3030	r, City or T Wil	own, State, Zi kens A	p Code) Jenue
Baltimore,	Pages 1 a nent of Hea ant: If Item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of I	Disposition (Nam crematory or o	ne of		Date		tion - City or T	
Balti	permit. Departn Importa any Inju		21. Signature of Funeral Service Licen	ade, Virect	tor	State A Baltimo			; 655 W.	Bal	timore	Street
	Physician		23a. art1. Enter the disea., or compshock, ir heart failure. List only of immediate of use (Final disease or condition	lications that caused to one cause on each line	. //		e of dying, suc			est,		Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a	consequence of							
9.3		ner	Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):						
68760,	The law requires that the death certificate be executed tte has been signed by the attending physician and age 2 should be detached for use as the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequence of):						
_	rtificate ng phys as the	Medical	IF FEMALE:	d		,						
O. Box	ne death certific the attending p hed for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome p 1 □Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 ☐ Ectopic pr 5 ☐ Other (sp				23	d. Date of deli Month	very Day Year
ds, P.O.	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying ca	ause given in P	Part i.	23e. Did to			the cause of death?
Division or Vital Records,	The law require has been age 2 shou	Completed							24a. Was a autop perfor	sy	prior to death?	topsy findings available ompletion of cause of
/ita	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?			-	1.	Place of Deat	n (Check only or	-		
0	ding Physion. After this of funeral dire	မ	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpatien 28a. Date of Injury	t 2 ER/Outp		OA Other: 4[28c. Injury at	Wursing Ho	me 5 Resid			rify)
on	Attending Physician: r death. ector: After this certificaby the funeral director, I	tion	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		ury M	Work? 1 ☐ Yes	2□No	200. 000000			
Divis	i ji te	Certification:	3 Suicide 6 Could not be determined	28e. Place of injur building, etc.	y - At home, fam (Specify)	n, street, factory	, office		28f. Location (S City or Tow	Street and on, State)	Number or Ru	ral Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical C		ysician: To the best of niner: On the basis of and manner state	examination and							
	To the To the Comp	M	29b. Signature and title of certifier				c. License num		:		signed (Monti	
			· Fa				1) 2501				26/6	S
			30. Name and address of person who	27/7	Han	monde	's Fen	y Ro	1212	27		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	arkal	, , ,	/				. 194

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar 35021 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 30, 2005 9:15 Ам Kathleen A. Fara 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Phoenix Baltimore 14226 Sawmill Court 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar. 24, 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Year) Min. 1 M 2 F Months Days Hours 59 New York 096-44-0207 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 🙀 No Baltimore Phoenix 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21131 USA 14226 Sawmill Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💢 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Geriatric Social Worker Social Work 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Quinn Arthur Ryan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14226 Sawmill Court: Phoenix. MD 21131 Jeffrey L. Fara husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cemation 3 Removal from State Hilltop Service Corp. 11/3/09 Towson, MD Other (Specify) 4 Donation 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d. Date of delivery Month Year Day contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

Completed by

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be reserved.

Baltimore, Maryland 21215-0036

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	e as the burial-trans	Modioal Evam	Medical Exam
within 24 hours after death.	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Madical Catification To De Completed by Dhucisian Madical Evamine	Dy Fillysicially
	ector, page 2 should	o Completo	ne combiere
within 24 hours after death.	in by the funeral dire	T. acition To	IIIICalloll, 10
within 24 hours after death.	completely filled i	Modical	Medical ce

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

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IF FEMALE: 23b. Was decedent pregnant in the past 12 moons? 1 □ Yes 2 ☑ No 9 □ Unknown	230	i. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	I death 3 - Ector						Date of delivery Month Day	/ Yea
Part II. Other significant con	ditions contri	buting to death but not resi	ulting in the underlyi	ng caus	e given in Part I.		23e. Did tobacc	use co	n ribute to the c	ause of deat
							1 ☐ Yes	2 No	3 ☐ Probably	/ 4 ☐ Unki
							24a. Was an autopsy performed? 1 □ Yes 2		o. Were autopsy prior to comple death? 1 Yes 2	etion of caus
25. Was case referred to med	lical				26. Place of De	ath (C	Check only (a)			
examiner? 1 ☐ Yes 2 ☐ No	Hos	spital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA	Other: 4 Nursing I	Home	5 Residence	6 🗆 0	ther (Specify)	
Z L Addident	estigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury		Injury at Work? 1 □ Yes 2 □ No	280	f. Describe how in	ury occ	urred	
	uld not be ermined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fa	ctory, off	ice	28f	. Location (Street City or Town, Sta	and Nur	nber or Rural Ro	oute Number
		cian: To the best of my known: On the basis of examina								

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month,

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

		1 = For State Registrar	State of Mar		epartmen Certificat			d Me		ene 2 () (09	3502
Physicia		Decedent's Name (First, Middle, Last, VIOLET OLIVIA TANZ		V					Date of Death Month	Day	Year 2 0 0 9	3. Time of Death
/Medica Examine	di :	4a. Facility Name (If not institution, give Greater Baltimo	re Medic	al Ctr		Tow	Location of D S O N	eath		4c. County Balt:	of Death imor	e Count
Funeral Director		5. Social Security Number 6. Set NONE 1 Usual Residence of Decedent 10a. State 10b. County]M 2∭X F	In yrs. last birth Yi	Months	Days 5		vlin. 1	Date of Birth Month, Day, 0/23/20	009		MD Od. Inside City Limi
the Marylan 28e-f show colified at	rector	MD BALTIMORE		BALTIMO		Code			10	Og. Citizen of V	/hat Coun	1 X Yes 2 □ N
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It has the marked other then "natural", or items 23a or 28e-f show other traumatic event, the Medical Examinations to citize an other traumatic event, the Medical Examinations and the rotified at	by Funerai Director	314 SOUTH MADEIRA 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S.	212 13. Was Decedif Yes, specific Yes	dent of Hi cify Cuba	spanic Origin n, Mexican, P Specify:	? (Specif uerto Ric	y Yes or No- an, etc.)		e - Americ k, White,	etc.
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Should be filed within and Mental Hygiene. is marked other then aumatic event, the Me	To Be (17. Father's Name (First, Middle, Last) PATRICK		FELDMAN			18. Mother's JENNIF		First, Middle, N	Maiden Sumam T	e) ANZM/	NA
and 2 shoulealth and Mm 27 is man		19a. Informant's Name/Relationship (7) JENNIFER TANZMAN/M			Mailing Address 4 SOUTH					-		
permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other ones.		20a. Method of Disposition 1 X Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signeyer of Funeral Service Cens		OHEB"S		other place and Addres	s of Facility	SOL	2009 LEVINS	20c. Location - REISTER ON & BR KESVILL	STOWI OTHE	N, MD RS, INC.
Physician /Medical Examiner purial-liansil	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sautematiky list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last	Due to (or as a Due to (or as a	consequence of	luchy)-):				espiratory arre	est,		Approximate Interval Between Onset and Death
the death certificate be by the attending physicie ached for use as the bu	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d. 23c. If yes, outcome of 1 □Live birth 2 4 □ Pregnant at til 9 □ Unknown	Fetal death	3 ☐ Ectopic p 5 ☐ Other (sp					Mo		Day Year
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f or Attending Physician: The law requires the after death. Director: After this certificate has been signe tin by the funeral director, page 2 should be come.	Be	25. Was case referred to medical examiner?	de contrati			Oth	The second second	Death (autops perform 1 Yes 2 Check only on	ned? 2 No	death?	
tending Physicath. tor: After this the funeral di	Certification: To	27. Manner of Death 1 PNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	1 Inpatient 28a. Date of Injury (Month, Day) 28e. Place of Injury	Yea <i>r)</i> 28b. Ti	М	28c. Injun Wor 1 🗆	4 🗀 14013	28	d. Describe ho	ence 6 Oth	red	al Route Number,
non hou		4 Homicide determined 29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	building, etc.	(Specify) my knowledge,	death occurred	at the tin	ne, date and	place, an	d due to the c	n, State) ause(s) and ma	inner as s	tated.
To the Hu within 24 To the Fu completel	Medical	29b. Signature and title of certifier	and manner state	ed.	29		e number	50001180		9d. Date signe	d (Month,	Day, Year)
Sta	te ar	30. Name and address of per in who of the control o	ompleted cause of dea	· Charle	Type, Print) SS+, F	Saltin	nove 1	NO	2120	4		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore Hospital Bon Secours If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 78 Yrs. 8. Date of Birth (Month, Day, Year) 12/6/30 6. Sex **Funeral** Min Days Hours 1 □ M 2 X F Months Director SC Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Item Medical Exact in an installation. Yes 2 □ No Baltimore N/A MD Director 10f. Zip Code 21223 10g. Citizen of What Country? 10e. Street and Number 2510 Fairmount St. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. African 1 ∐Yes 2 ∑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: American ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Self Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Binkey Thomas Samuel Thomas ್ತ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Raltimore, MD 21223 19a. Informant's Name/Relationship (Type. Print) 2510 Fairmount St., Baltimore, MD Patricia Rice/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition ์วี/09 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Balt.County,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Se vice Lionsee Rd, Balt: 5126 Belair complications that caused the death. 23a. Part 1. Enter the disease, shock, or heart failure. L Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dus to lot as a Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the for use as yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 No nis certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions þ 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerforme 2 No 25. Was case referred o medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 2 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Sepatient 1□ Yes 2 ER/Outpatient 3 DOA Medical Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Natural Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

State Registrar 31. Date filed (Month, Day, Year) 0 2 2009

Name and address of person who complete

32. Registrar's Sigi

29c_License number

29d. Date signed (Monty, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25a pe Maryland 99 enar/702/1096 Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 20 00 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Parkville Oak Crest Care Center 8. Date of Birth (Month, Day, Dec. 10, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 80 1 □ M 2 🗓 F 212-26-0738 Dec. 1928 Maryland Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 XNo Baltimore Parkville MD Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 5 8820 Walther Blvd. Apt. 1502 21234 U.S.A. items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Specify: White or, Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 X Widowed 4 □ Divorced "natural", 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 12 is marked of er 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary McDomman Edgar Webster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is Thomas Gedra/ 1416 S. Mansfield, Stillwater, OK 74074 Evans Fueral Chapel 10/22/09 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Forest Hill, MD 4 □ Donation 5 □ Other (Specify) 21. Sign ture of Funeral Servi¢e License 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services
8800 Harford Rd. Parkville, MD 21234 left 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final Sepsis **Physician** /Medical Due to (or as a consequence of) Pneumonia Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2. No 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ N 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 N 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide e Funeral I ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated. To the within 2
To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific

State Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

32. Registrar's Signature

	1	For State Registrar	State of Ma	ai yiaiiu		tificate of		vieritai Hyg R	leg. No.	009	35025	
Physiciar		1. Decedent's Name (First, Middle, Las						2. Date of Dea Month	Day	Year 2009	3. Time of Death	
/Medica		Floyd Henr 4a. Facility Name (If not institution, giv		ıbb	Jr.	4h City Town o	r Location of Death	October		unty of Death	12:30 AM	
Examine		1138 Ferber Avenu					no1d			nne Arur	ndel	
Funeral Director		5. Social Security Number 6. S 201–16–4314		e (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March 1	, Year) 6 192	9. Birthpla Count	lace (State or Foreign try) PA	
land	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation				10	Od. Inside City Limits	
Mary	5	Maryland Anne A	rundel				Arnold				1 ☐ Yes 2 ☑ No	
or 28		10e. Street and Number				10f. Zip Code			10g. Citizen	of What Count	:ry?	
ath wi	<u>a</u>	1138 Ferber Aven					21012			USA		
be filed within 72 hours after death with the Maryland tital Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Moderal Evarrings must be retified at	2	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 ☑Yes 2 ☐ N If Yes, Give Year or Dates:			Vas Decedent of H fYes, specify Cub I □Yes 2 ☑ No	dispanic Origin? (S an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	1	Race - America Black, White, e pecify: W		
permit. Pages 1 and 2 should be filed within 72 hol Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura any injury or other traumatic event, the Modical It	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Solution							Soci	o. Kind of Business/Industry Social Security Administration		
Hygie w		12 17. Father's Name (First, Middle, Last,	<u> </u>		<u></u>	aims Adji		ne (First, Middle,				
ld be lental ked o	0		rubb Sr.				Cleo	Wolfe		,		
and N is mar	-	19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	ng Address (Street	and Number or Ru	ıral Route Numbe	r, City or To	own, State, Zip	Code)	
and 2 lealth m 27 i		Shirley M. Grubb	(spous				Avenue, A					
iges 1 nt of H or ott		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □	Removal from State	20b. Pla cer Ind	ice of Dispo metery, cren lantov	sition (Name of matory or other pla In Gap L Cemeter	Nov.	Date 04		tion - City or To		
artme artme ortant injury	-	4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Lice		Nat		L Cemeter . Name and Addre					nnsylvania	
any pen		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122										
Physician /Medical		23a. Part 1. Enter the discase, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. each lir	icins	sons	1	ng, such as cardiad	or respiratory ar	rest,		Approximate Interval Between Onset and Death	
Examiner	<u>.</u>	Sequentially list conditions,	b. Due to (or as									
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Areating Trystolar, the law requires that the bear tool or death. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use	ysician/iv	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal o	death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		230	d. Date of delive Month	ery Day Year	
s that	Dy Prny	Part II. Other significant conditions	_		_	nderlying cause gi	ven in Part I.	23e. Did to	obacco use	contribute to th	ne cause of death?	
s been sign should be									No 3 ☐ Prob	oably 4 Unknown		
has be	Completed							24a. Was autop perfo		24b. Were autop prior to cor death?	psy findings available mpletion of cause of	
tificate ha	3 9	25. Was case referred to medical					26 Place of Dor	1 ☐ Yes	2 No	1 ☐ Yes	2 N o	
his certificate I	0	examiner?	Hospital: 1 ☐ Inpatie	ent 2 🗆 E	R/Outpatier	nt 3 DOA Ott	205.	Home 5 Resid		☐Other (Specific	·y)	
ath. or: After thine funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	1	iry y, Year)	28b. Time of Injury	Wo	iry at	28d. Describe h			,	
rs after de ral Directa	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, et	c." (Specify))	eet, factory, office		City or Tov	vn, State)		al Route Number,	
or the nospital of Attenuar within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Medical	(Check only 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	of examination	rledge, deat on and/or in	vestigation, in my	opinion, death occi	e, and due to the urred at the time,	date and p	lace, and due to	o the cause(s)	
with Con	2	29b. Signature and title of certifier	DM 90			D3	se number		Octo	BER	30,2009	
-		30. Name and address of person who	completed cause of o	leath (Item	23a) (Type,	Print)	les St	reet P	altin	nove M	MYLAND	
State	3	31. Date filed (Month, Day, Year)	32. Pegistr	ar's Signatu	re							

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

09-08395 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 35026 State of Maryland / Department of Health and Mental Hygiene Jerome Gunther, Jr 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day October 29, 2009 1430 hrs Medical Examiner Jerome Gunther, Jr. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Dundalk 3416 Dunhaven Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Months | Days | Hours | Min. | December | Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Min. Director 219-82-4095 1 X M 2 F 14. Marvland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 X No Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other trannatic event, the Medical Examiner must be notified at once. Baltimore Dundalk Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 U.S.A. 3416 Dunhaven Road 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status White, etc. Armed Forces? 2 Married Never Married Yes White Specify 4 X Divorced If Yes, Give Year 1 Yes 2X No specify: Widowed ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Tulkoff Food Elementary/Secondary (0-12) Products, Maintenance Electrician 12th2vrs 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dolores Skwirut Be Jerome Gunther, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) County Road 326, Rosebud, Texas 76570202 Joyce L. English(sister) 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition November crematory or other place) Burial 2 X Cremation 3 Removal from State 2, 2009 Baltimore, Maryland Bavview Crematory Donation 5 Other Specify 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses Dundalk Avenue Baltimore, Md.21222 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Physician Death Medical a Narcotic (morphine) & alcohol intoxication Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical XUNPENDED signed by the attending physician be detached for use as the burial 23a,27,28a-f,permE, g897 11/10/09TT Box 68760, 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Dav Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. à 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has b ector, page 2 sh death? performed? ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifit completely filled in by the funeral director, I 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ examiner? Hospital: DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 1 Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Certification: 1___ Yes 2 X No 1 Natural 5 Pending unk Fd 10/29/09 Fd 1650 hrs 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3416 Dunhaven Rd Dundalk, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide (Specify) Dundalk, Homicide residence 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State 31. Date filed (Month, Day, Year)
Registrar

Zabiullah Ali, M.D.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

2. Redistrar's Signature

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

October 30, 2009

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OCTOBER ROSALIE GREEN LTLLTAN 30, 2009 8:53 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner COURTLAND GARDENS BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 220-24-8097 Months 91 MD Director 06/01/1918 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evaminat must be rediffed at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD N/A BALTIMORE 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21215 USA 7015 PARK HEIGHTS AVENUE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 💢 No WHITE \$ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) BOOKKEEPER 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GREEN MOLLIE STEIN HYMAN ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) REUBEN YUDKOWSKY / FRIEND 3712 W. STRATHMORE AVENUE BALTIMORE, MD 21215 20b. Place of Disposition (Name of LUBER TAMID) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/30/2009 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 Signature of Funeral Service 8900 REISTERSTOWN ROAD 23a. Parvi. Enter the disease or complications that caused the reath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to or as a construction of): ORO CALCINOMIA wan /Medical Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine the Hospital or Attending Physician: The law requires that the death cartificate be exacuted burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the signed by the attending place as the datached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ paga 2 should be 2**⋈** № 1 🗌 Yes 3 Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No 24a. Was an has autopsy performe certificata 1 □Yes 2/1 No ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: After this c funeral dire 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Aath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Natural 5 Pending investigation ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number address of person who completed cause of death (Item 23a) (Type, Print) Smith ALE, BALT, MD 1/209

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

My

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 8 State of Maryland Department of Health and Mental Hygiene 2009 Certificate of Death For State Registrar 3502**8** 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** JOSEPH HAYNES OCTOBER 29 2009 11:08 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner RANDALLSTOWN GENESIS KANDALLSTOWN Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/05/1930 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1**⊠** M 2□ F 79 Director Tennessee 301-24-3591 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County or than "natural", or Items 23a or 28a-f show 28a-f show 1 ☐Yes 2 X No Director Maryland Frederick Mt. Airy 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 13655 Unionville Rd. 21771 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or Item Iny or other traumatic event, It wendled Evaluation. 1 XYes 2 No If Yes, Give Year or Dates: 1950-53 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 □Yes 2 No Specify: White δ 3 Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 5 teacher public school 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Annie Thomas Crowell Ernest Raymond Haynes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) J. Nathan Haynes/son 13655 Unionville Rd. Mt. Airy, MD 21771 Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of
Important: If It
any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation 10/31/2009 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hartzler Funeral Home affarine 11802 Liberty Rd. Libertytown, MD 21762 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PARKINSON'S Immediate Cause (Final DISEASE ENDSTAGE **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine g physician and as the burial-transit Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 s autopsy performed? 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: d in by the f 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours af e Funeral Di letely filled in 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou **To the Fune** completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0058965 October 30th 2009 Jalma Knowasn 1801 Wentworth Road, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar SAIMA

MD

Physic /Medi Exami

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It a Modical Examination to condition at once.

Baltimore, Maryland 21215-0036

Physician /Medical xaminer

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Sta

	Registrar Certificate of Death Reg. No.													
an	Vivian LaRue Haines October 25 2009 6:32													
cal	do Espilita Name (Mand institution with attended number) Ab City Taylor and position of Doobt													
ner	137 Unic			/		Bridge	eaur	Carroll						
	5. Social Security N			ge (In yrs. last birthd	ay) If Under 1 Yea	r If Under 24 H	lrs. 8. Date of Birth	9 F	Birthplace (State or Foreign					
	212-24-6	936	1□M 2 X F	81 Yrs	Months Days	Hours M	in. (Month, Day, Jan. 4,	1928 M	aryland					
	Usual Residence of													
	10a. State	10b. County		10c. City, Town or	Location				10d. Inside City Limits					
S S	MD	Carr	oll	Union	Bridge				1 X Yes 2 □ No					
Director	10e. Street and Nur	mber			10f. Zip Code		1	0g. Citizen of What	Country?					
a	137 Un	ion Br	idge Road		2179	1		USA						
Funeral	11. Marital Status		12. Was Deceden Armed Forces	t Ever in U.S.	3. Was Decedent of	Hispanic Origin?	(Specify Yes or No- erto Rican, etc.)		merican Indian,					
匠	1 Never Marri	ied 2□ Mar]No	1 ☐ Yes 2 ☐ YN		erio riicari, etc.)	Black, Wi						
l b	3 X Widowed	4 Divorced	Year or Dates	:	To les 24	э эреспу.		Specify:	white					
Completed by	(Spec	15. Deceden	t's Education st grade completed)	16a. De	ecedent's Usual Occ	upation e during most of v	vorkina	16b. Kind of Busines	ss/Industry					
g	Elementary/Secon		College (1-4or	5+) lif	e. DO NOT use retir	red)		-1 -44-4	C					
S	11			sea	mstress	Ţ		clothing	ractory					
Be	17. Father's Name (lame (First, Middle, M	Maiden Surname)						
은	Maurice	Lee Gr	inder			Luia M	lae Hooper							
	19a. Informant's Na	_			_		Rural Route Number							
	Karen Mil		ughter				d Union B							
	20a. Method of Disp 1 XBurial 2		3 ☐ Removal from State		sposition (Name of crematory or other pi			20c. Location - City						
	4 ☐ Donation			Pipe Cr	reek Cemet			Linwood, 1						
	21. Signature of Fu	neral Service	Licensee	60 1	22. Name and Add	ress of Facility E	Hartzler F	uneral Ho	<i>lome</i>					
_	an	Truse	V. Wark	year 1			nion Bridge		91					
	23a. Part 1. Enter the shock, or hea	he disease, or rt failure. List	complications that coord	d the death. Do not line.	enter the mode of d	ying, such as card	fiac or respiratory arre	est,	Approximate Interval Between					
	Immediate Cause (disease or condition	(Final n	moto	estatic	breast	Can	cer		Onset and Death					
	resulting in death)		Due to (or a	s a consequence of):	-									
	Sequentially list cor	nditions	b											
ine	cause. Enter Under Cause (Disease or	ryadiate	Davi to (or 8	s a consequence of):										
am	that initiated events resulting in death) L	3	c											
an/Medical Examiner	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Due to (or a	s a consequence of):										
dic	d													
Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of													
ian	23b. Was decedent in the past 12	months?	1 Live birth	2 Fetal death	3 Ectopic pregna	ncy		23d. Date of Month	delivery Day Year					
Physici	1 □Yes 2 0 9 □ Unknown	No	9 Unknown	at time of death	5 ☐ Other (specify)									
			ons contributing to death	but not resulting in the	e underlying cause o	iven in Part I	23e. Did tob	acco use contribute	to the cause of death?					
by					5 4.1.55.7,g 54460 g]Yes 2 No 3 Probably 4 Unk						
ted							_							
Completed by							– 24a. Was ai autops	v prior i	autopsy findings available to completion of cause of					
S							perform 1 □ Yes 2	ned? death						
Be	25. Was case referrexaminer?						Death (Check only on	e)						
မ	1 ☐ Yes 2 🔀		Hospital: 1 ☐ Inpa		III 3 LI DOA	ther: 4 Nursing	Home 5 Reside	ence 6 Other (S	pecify)					
e E	27. Manner of Death Natural	h 5 ☐ Pendin	28a. Date of In (Month, D	jury 28b. Tim <i>lay, Year)</i> Injui	ry W		28d. Describe ho	w injury occurred						
cati	2 ☐ Accident 3 ☐ Suicide	investig 6 ☐ Could	gation		M 1	□Yes 2□No								
ŧ	4 ☐ Homicide	determ	inod Zoe. Place of II	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office		28f. Location (St City or Town		Rural Route Number,					
ပ္ပ	00 0 0						4							
Medical Certification: To	29a. Certifier (Check only one)	2☐ Medical	ng Physician: To the bes Examiner: On the basis	of examination and/o	eath occurred at the r investigation, in my	time, date and play opinion, death or	ace, and due to the c ccurred at the time, d	ause(s) and manner ate and place, and c	r as stated. fue to the cause(s)					
Med	29b. Signature and	title of dertifie	and manners	rated.	29c Lice	nse number	2	9d. Date signed (Mo	onth Day Year)					
	255. Oignature and	11/	MIM MIT		7	1414	4	10 10	6/09					
		- V &			٠ (١ -	1010	/	101/						
	30. Name and addre	ess of person	who completed cause of	death (Item 23a) (Typ	pe, Print)	1 7/1	Stroot	Frentori	ck, MD 2176					
te	31. Date filed (Mont	h, Day, Year)	32 Regis	trar's Signatur	1 .00		JIIEE !	110001	71 0 2					
ar	A	10V 02	2009 Sene	a B. A	Barro									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 35030 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** TOWARd 331 200 115 3 /Medical 4c. County of Death Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** BurNER 77 IASH IEN 0 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday Birthplace (State or Foreign County) cial Security Number 6. Sex **Funeral** Year) 934 Months 18-30-5130 Days Hours 1 **X** M 2 □ F ana Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town of Location 10b. County Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evaninal must be notified at gones. 10a. Glen 1 ☐ Yes 2 No Be Completed by Funeral Director 10g. Citizen,of 10f. Zip Code 💉 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes 2 __No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11. Marital Status 1 ⊟Yes 2 M If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during re-life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 18. Moth 17 Father's Name (First, Middle, las VOLMAN ည 19a Ipformant's Name/Relationship (Type. Print) ջդ Rural Route Number, City oդ Town, State, Zip Code) 19b. Mailing Address (Street and Number ones 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Burial 2 Cremation Date 20c. Location - City or Town, State 3 Removal from State Glen Burnie, md 2061 10/30/2009 5 ☐ Other (Specify) Funeral Home permit. 21. Sign ture of Funeral Service Licensee 23a. Party Enter the disease, or complications that caused the death. shook, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death te Av+ terioscherotic 3845E Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to limited atte cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1 □Yes 2 ZNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 6 Residence 6 Other (Specify) Hospital: 2 🗌 No 1X Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the and manner stated. 29d. Date signed (Month, Day, Year) 1) eouty 29b. Signature and title of certifier 29c. License number

Registrar

State

30. Name and address of person who completed duse of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

ONES

32. Registrar's

09-08376

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2009 3503 Terri Diane Jackson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day October 28, 2009 2320 hrs **Medical Examiner** Terry Diane Jackson 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death c. County of Death **Baltimore County** Gwynn Oak 1813 Colonial Road If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months Days Hours Director 09/15/1953 212-60-7551 56 MD 2 X F Country) М Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Baltimore Gwynn Oak Yes 2 X No MD 28a-f show notified at once. filed within 72 hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 1813 Colonial Road 21207 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 1 X_{Never Married} Armed Forces' White etc 2 2 X No Yes White Yes 2 X No specify: Divorced If Yes, Give Year 3 Widowed 4 Specify. ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical marked other than Postal Worker U.S. Postal Service 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be finent of Health and Mental Be Louis E. Jackson Lola H. Barker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathy J. Jackson (Sister) 1353 North Rolling Road, Catonsville, MD 21228 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery. Date 20c. Location - City or Town, State crematory or other place) Burial 2 XCremation 3 10/30/2009 mportant Bayview Crematory Baltimore, Maryland Other Specify: Donation 5 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, 4107 Wilkens Avenue, Baltimore, Maryland 21229 art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause of each line Between Onset and /Medical Death a, Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical attending physician or use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Day Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months Pregnant at time of death Other (Specify) Yes 2 No 9 ✓ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of performed? death? After this certificate Yes 2 ✔ No i No 25. Was case referred to medical director. 26.Place of Death (Check only one) Be examiner? Other₄ Hospital: ER/Outpatient 3 Inpatient 2 Nursing Home 5 Residence 6 V Other: Scene ဠ 1 ✓ Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Yes 2 Pending Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 29, 2009 W5 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ling Li, MD Assistant Medical Examiner

State Registrar

31. Date filed (Month, Day

32 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1- For Amend Items 10e,16b per in, g897,11/12/09dhb Certificate of Deat	ath	Reg	.n _o 2009	35032			
	Dhysisi	-	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death			
	Physici /Media		Joseph Bart Kraus Sr.		ct 29,		4:03P M			
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location	tion of Death		4c. County of Death				
M			Carroll Hospice Dove House Westmins			Carroll				
	Funeral		Months Days Hour	nder 24 Hrs. 8. Durs Min.	Date of Birth Month, Day, Y	9. Birthp (ear) Coun	lace (State or Foreign htry)			
	Director		212-34-3155 73 Yrs. 73	6 –	13-19	36 Mary	land			
	and w	1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			11	0d. Inside City Limits			
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	he M	Director			100	0'''				
	h with th	al Dir	10e. Street and Number 669 Grant Prive 10f. Zip Code 1732	25	109	. Citizen of What Coun USA	itry?			
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Baltimore,	Pages nent of int: if ite		1 XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Evergreen Memorial	; 1 11_3_3	2009 F	'inkshura	MD			
≢	permit. Page Department of Important: If any injury or once.		21. Signature of Euneral Service Licensee		1		•			
Ba	Per Jana Per		Phomas D. Fletcher III 254 E. Mair							
			23a. Part 1. Enter the disease, or complications that cause dithe death. Do not all 1 the mode of dying, such shock, or heart failure. List only one cause on a chaine	ch as cardiac or res	spiratory arrest	t,	Approximate Interval Between			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

rayrie Lee Reary	1	Certificate of Death Reg. No. 2009 3503
Physicia	n/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year 4.047 has
ledical Examin		Wayne Lee Keary October 30, 2009 1247 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
		7215 Rolling Mill Road Dundalk Baltimore County
Funeral Director		5. Social Security Number 215-54-4652 1X M 2 F 59 Yrs. 59 Yrs. 6. Sex 7. Age (In yrs. last birthday) 1X M 2 F 59 Yrs. 6. Sex 7. Age (In yrs. last birthday) 1X M 2 F 59 Yrs. 6. Sex 7. Age (In yrs. last birthday) 15 Under 1 Year 15 Under 24 Hrs. 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State or Foreign Country) Maryland
Aaryland 28a-f show any 1at once.		Usual Residence of Decedent 10a. State
th the Maryland 23a or 28a-f sho	Director	3502 Linbelle Terrace 21234 USA
imore, MD 21215-0036 Pages I and 2 should be filed within 12 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	— L	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 2 Married Forces? 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 3 Widowed 4 X Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only bighest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done) 15b. Kind of Business/Industry
136 thin 72 hours te. than "natur edical Exam	ompleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) +1 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self Employed Advertising
1215-0036 I be filed within 72 ental Hygiene. arked other than '	BeC	17. Father's Name (First, Middle, Last) Eugene Keary 18. Mother's Name (First, Middle, Maiden Surname) Mary Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
AD 2 2 should 1 and M 27 is m matice	_ ,	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary T. Keary/ Mother 14 Tenbury Rd. Lutherville, Md. 21093
re, s l an f Hea If iter	İ	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11-4-09 Timonium, Md.
Baltimo permit. Page: Department o Important:		21. Signature of Fundral Strice Licens, 22. Name and Address of Facility Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204
Physician Medical xaminer	10	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a, Multiple Gunshot Wounds Approximate Interval Between Onset and Death
Varianci		or condition resulting in death) Due to (or as a consequence of):
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
e	Examiner	(Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of):
xecuted n and I - trans		d. UNPENDED AMENDED
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		1
O. Bc at the des 1 by the s trached fo		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
S, P.	ed b	1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available
cord e law req e has bee	Completed by	autopsy prior to completion of cause of performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal Reisian: The certificate		25. Was case referred to medical 26.Place of Death (Check only one)
'Vita	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursing Home 5 Residence 6 ✓ Other: Scene 27 Manner of Death 128a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred
ision of Vital Rec Attending Physician: The I rdeath. ector: After this certificate by the funeral director, page		1 Natural 5 Pending Oct 30, 2009 1230 hrs 1 ✓ Yes 2 No Subject shot
Divisi Hospital or Att 24 hours after de Funeral Direct	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined Specify) Office Suicide 4 Homicide Investigation 5 Suicide 6 Could not be determined Specify) Office See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7215 Rolling Mill Road, Dundalk, MD
To the Hospita within 24 hours to the Funeral completely fille	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
F # F 5	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 31, 2009
		20 Nam an address of person who completed cause of death (Item 23a)
+1		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
St Regist	ate trar	ALIEN AND AND AND AND AND AND AND AND AND AN
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			1 - For State Registrar	State o	of Marylan	id / Depa	artment rtificate	of H	lealth a Death	and M	lental Hy	giene Reg. No	200	9	35	034
	Physicia /Medic		1. Decedent's Name (First, Middle Patricia	, Last)	Kier						2. Date of Dea Month October	ath	, 2ŏ		3. Time o	
	Examin	er	4a. Facility Name (If not institution 8300 Aqueduct 1	Road				Pot	omac			4c.	County of ontgo	Death mer		
	Funeral Director		5. Social Security Number 104-30-0042 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. 71	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birt (Month, Da August 6	, Year) , 193	38 N	Birthp Cour WeW	place (State htry) York	or Foreign
paritiniore, Maryland ZIZI3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, in Medical Event and the rolling of an once.	Funeral Director	Maryland Mont 10e. Street and Number 8300 Aqueduct R 11. Marital Status	gomery oad 12. Was Dec		Omac 10f. Zip Code 10g					Un	10d. Inside City Limit 1 □ Yes 2 ☑ No 10g. Citizen of What Country? United States 14. Race - American Indian,					
	Completed by Fi	1 Never Married 2 Narri 3 Widowed 4 Divorced 15. Decedent (Specify only highes Elementary/Secondary (0-12)	ed 1 ∏Yes If Yes, G Year or D	2 X No lve ∂ates;	16a. Dece (Give life.	1 □Yes 2 dent's Usual kind of work DO NOT use memak	No Occupa done de retired	Specify:			16b. Ki	Specify: ind of Busin	ness/Ind	White		
yiand	Mental Hygiarked othe	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name					ret Ka	rst, Middle, Maiden Surname)							
e, Mar	Health and em 27 is mem 27 is mether traum	100	19a. Informant's Name/Relationsh Thomas J. Kiern 20a. Method of Disposition			8300	Aqued	uct	Road	, Po	otomac,	Mar		20	854	
Daillillor	rtment of rtant: If It in injury or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St	ecify)		Place of Disponentery, cres	aven Ce	mete	ry	200		Silve	er Spri	ing,	Maryla	
D S	Depar Impor any Ir		21. Signature of Funeral Service I	must							ral Home/ nue, Rock		ville, , Mary	Inc.		
	hysician /Medical xaminer		shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)	a. Ad e	enocarci (or as a conseq	noma o					or respiratory ai	rest,		1	Approxima Interval Be Onset and 5 Mont	Death
of ou,	physician and s the burlal-transit	dical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c													
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order, r	en signed by the audid be detached to	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute													
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ding Physic ding Physic h. After this co funeral dire	tion: To	1 I Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Ho							dome 5 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred							
Islor Affen	ours after death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined building, etc. (Specify) M 1 Yes 2 No 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 287. Location (Street and Number or Rural Factory)									l Route Nui	mber,			
the Hosni	within 24 hours a To the Funeral completely filled	ledical	(Check only 2 Medical E	Physician: To the examiner: On the b and man	e best of my kno pasis of examina ner stated.	wledge, deat ation and/or in	vestigation,	in my o	pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s date and) and mann d place, and	ner as s d due to	tated. the cause(s)
P	with To Cor	Σ	29b. Signature and title of certifier	LL					number 61040				te signed (i			
			30. Name and address of person v Charles Rudin, N	1.D. 401	North	Broadw		reet	, Bal	Ltimo	ore, Mai	cyla	nd 21	231		
	Stat Registra		31. Date filed (Month, Day, Year)	2000	Rejetrar's Signa	lture	7	>								

DHMH 17 Rev 1/2001

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amend 15a per fib 8897 11-2 19 11

			For State Registrar	State of Maryla		rtificate of		Re	2 0 Seg. No.	09	350	35		
П	Physici	an	1. Decedent's Name (First, Middle, La.					2. Date of Death October		ð ^g r	3. Time of De 3:20 F			
44	/Medic	al	4a. Facility Name (If not institution, giv	. Livingsto	r Location of Death	L	4c. County		3.20 1	IVI				
	Examin	er	3715 Milford				timore			IA				
E	Funeral		5. Social Security Number 6. S		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11-25-4			place (State or Fi	oreign		
	Director		235-70-4498 Usual Residence of Decedent	LM 2AF 63	Yrs.			11-25-4	45	W	· VA			
	yland yland		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				1	10d. Inside City L	imits		
	a-fsh	ctor	MD NA	В	altimo	ore					Y∏Yes 2[□No		
	ith th	Director	10e. Street and Number			10f. Zip Code		11	0g. Citizen of		ntry?			
	sath w	eral	3715 Milford	Avenue 12. Was Decedent Ever in U	16 19	2120		acifu Vac or No	USA		can Indian,			
21215-0036	within 72 hours after death with the Maryland jene. Jene. r than "natural", or items 23a or 28a-f show the Medical Examinar must be untified at the Medical Examinar must be untified.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2XNo		Rican, etc.)	Bla	ck, White,	erican	can		
5-0	72 hc 'natui	Completed	15. Decedent's Ed (Specify only highest gra	ducation ide completed)	i (Give	dent's Usual Occup	during most of work	king	16b. Kind of B	usiness/In	dustry			
121	within iene. • than "	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	d)		Forest	- На	ven N.H	Ħ.		
d 2	filed Hyg othe	Be Co	12th Grade 17. Father's Name (First, Middle, Last)	2yrs.	111	ursing	18. Mother's Nam	e (First, Middle, N			VCII IV			
ılan		To B	Thomas C.	Finley			Louvini							
lary	2 short and 1 is ma		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street						44		
6, ≥	1 and Health em 27 ther to		Lavina P. Bure 20a. Method of Disposition	h-Daughter	Place of Diene	4 Remin	- :	Date	ndsor					
Baltimore, Maryland	permit. Pages 1 and 2 should by Department of Health and Menti Important: If item 27 is marked any injury or other traumatic e once.		1 Burial 2 Cremation 3 C 4 Donation 5 Dother (Specif	Removal from State Ki	ng Me	matory or other play morial	1	31-09	Randal	llst	own, MI			
Ba	permit Depar Impor any ir		21. Signature of Funeral Service Licer	M. Wy/c	e 9	2. Name and Addre	erty Roa		allst	al Hown,	MD 21	A. 133		
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only		est,		Approximate Interval Betwee Onset and Dea	en ath						
The same	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. OVARIA		_	4 YRS	;						
	Examiner		1	Due to (or as a conse	quence or):									
	₽ .∺	ner	iner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Unuarying Cause (Disease or injury that initiated events	Due to (or as a conse	quence of):							
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	guanca of:									
68760,	tificate be executed g physician and as the burial-transit													
687	tificate g physas the	edical		d										
O. Box	The law requires that the death cert ate has been signed by the attendingage 2 should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 💆 No 9 □ Unknown	23c. If yes, outcome of preging the preging of the pregnant at time of a Unknown	tal death 3 [☐ Ectopic pregnand ☐ Other (specify) _	ey			ate of d <i>e</i> liv onth	very Day Yea	¥r		
rds, P.	w requires that s been signed b should be deta	ed by Pr	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	inderlying cause giv	ren in Part I.				the cause of deal			
Division of Vital Records,	Physician: The law re r this certificate has bee ral director, page 2 sho	Completed by						24a. Was a autops perforr 1 \(\text{Yes} \)	v I	Were autoprior to codeath?	opsy findings ava	ailable se of		
/ita	cian: ertifica ector, p	Be C	25. Was case referred to medical examiner?					th (Check only on						
of\	Physician: r this certific ral director, I	ည	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie		4 LI Nursing H	ome 5 Reside			M HOSPI	ICE		
on	Attending r death. ector: After by the funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Wor	k? Yes 2□No	28d. Describe ho	w injury occur	red				
Divisi	= gifte	Certification:	3 Suicide 6 Could not b 4 Homicide determined		home, farm, st cify)	reet, factory, office		28f. Location (St City or Town	reet and Numi n, State)	ber or Rur	al Route Numbe	r,		
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in	Medical C		nysician: To the best of my kr niner: On the basis of examin and manner stated.										
	To the Complete	Me	29b. Signature and title of certifier	· -		29c. Licens	se number	2	9d. Date signe					
			1 longhotta	1 MD		04	3934		10/2	29/2	2009			
_			30. Name and address of person who	completed cause of death (Ite	em 23a) (Type,	PRUL !	DIACE	BALTI	Manc	6.4	2009			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature 2	hanked!	HILL	4-10111	COKE	lot	ب عرباد	1		
	Registr	- 1	NOV 02	2009 Lenur	1 Pt. 1	gur								

DHMH 17 Rev 1/2001

09-08383 David Lee

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35036 2009 1- For State Certificate of Death Rea. No Registrar 2. Date of Death Physician/ Month Day October 29, 2009 0734 hrs **Medical Examiner** \boldsymbol{a} c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** Randalistown Northwest Hospital If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Country) Min Months Days Hours Director -98-6172 02 2 1 X M Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. Count 1 Yes 2 No items 23a or 28a-f show arion must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 7800 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Pages I and 2 should be filed within 72 hours after death variet of Health and Mental Hygene.

The state I file and 75 marked other than "natural", or item and the fired the fired to the framatic event, the Medical Examiner must be not other transmatters. Armed Forces? Never Married 2 Married Yes 2 No specify: 4 Divorced Give Year Yes Specify: Vnite Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 18.Mother's Name (First, Middle 17, Father's Name (First, Middle, Last Be (Street and Number ပ 19b. Mailing Address 20b. Place of Disposition (Name of cemetery, 2 Cremation 3 crematory or other place) Removal from State Burial Baltimore. MD tant: Other Specify Donation 5 ature of Funeral Service Licerise Pilce (21229) Balto. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death Myocardial hypertrophy Immediate Cause (Final disease raminer Due to (or as a consequence of) or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Couse Examiner (Disease or injury that initiated Due to (or as a consequence of): requires that the death certificate be executed events resulting in death) Last Physician/Medical X UNPENDED AMENDED 23a,27, permE, g897 11/13/09 TT Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Day Year Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. o ģ Yes 2 No 3 Probably 4 V Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? Yes 2 ✓ Yes 2 No 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical of Vital Be examiner? Hospital: 1 Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 this 1 ✓ Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 28c. Injury at Work? Manner of Death Certification: 1 X Natural Division Yes 2 No Pending within 24 hours after death.

To the Funcral Director: the Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) determined Homicide

Registrar

Medical

29a. Certifier 1 (Check only one)

29b. Signalu

Laron Locke MD. 31. Date filed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

October 29, 2009

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

egistrar's Signatur

			1- State of Maryland / Department of Health and N Registrar Certificate of Death	vientai Hyg R	eg. No. 2009	35037
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dear	th Day Year	3. Time of Death
-0.	/Media	cal	TE-VERIA LEE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	OCTOBER		
	Examir	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HOWARD CONTY GENERAL HOSPITAL COLUMBIA	1	4c. County of Dea	ıtrı
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 3. Months Days Hours Min.	8. Date of Birth (Month, Day	Year) 9. Bin	rthplace (State or Foreign puntry)
	yland		Usual Residence of Decedent 10a. State 10b. County • 10c. City, Town or Location			10d. Inside City Limits
	Ba-f s	Director	mb Howard Ellicoff City			1 □ Yes 2 ➡No
	with the			1	Og. Citizen of What Co	ountry?
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 1/4 yes, specify Cuban, Mexican, Puerte	pecify Yes or No-	14. Race - Am	erican Indian,
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, tre flection from the results of the flection from the flection from the flection from the flection flection from the flection flection flection from the flection f	by	If Yes, Give 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☑ Divorced Year or Dates:	o Hican, etc.)	Specify:	
15-(n 72 h "natu edical	olete	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Business	/Industry
212	d withi	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Administrator		Baltimo	re County
Maryland	be de de ev	Be	17. Father's Name (First, Middle, Last)		Maiden Surname)	,
ıryla		မ	Larrie Butler Sr. Earth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru		r City or Town, State.	Zio Code)
	교부스로		Marc C. Lee Son 15507 Norwecian Co	Burt Bo	wie, mi)	20716
ore	t of	8	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date /	20c. Location - City or	Town, State
altimore,		1		3-09	BIKrids	e MD.
Ba	permit. Departi Import any inj	l l	Vaughr C. Juene 5151 Baltmore	Ja Linua	I Pike B	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arr	rest,	Approximate Interval Between
5	Physician /		Immediate Cause (Final disease or condition resulting in death) a. CORONARY ATHEROSCLEROTIC DI	SEASE		Onset and Death
1	/Medical Examiner		Due to (or as a consequence of): OVARIAN CANCER			2 MONTHS
	D #	iner				S N.001117
	xecute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last			
92289	lificate be executed g physician and as the burial-transit	edical E	d			
	= 0, c		IF FEMALE:			
O. Box	requires that the death certific been signed by the attending p hould be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1		23d. Date of de Month	blivery Day Year
ς, σ.	w requires that the de been signed by the should be detached	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
ord	require	ted l	HYPERLIPIDEMA	1 🗆 Y	es 2 No 3 F	Probably 4 ☑ Unknown
al Records,	The law ate has b	Completed	HYPERTENSION	24a. Was a autops perform	by prior to death?	utopsy findings available completion of cause of
Vital	Physiclan: r this certific ral director,	Be c	examiner?	th (Check only or		
Division of	ding Physiclan: h. After this certifica	Certification: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ence 6 Other (Special Countries)	ecity)
Sior	tendin leath. tor Af the fur	catio	2 Accident investigation M 1 Yes 2 No			
Ξ	lor At after c birect	ertifi	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S. City or Tow	treet and Number or F n, State)	tural Route Number,
)	To the Hospital or Attending Powithing As Johns after dealh. To the Funeral Director. After completely filled in by the funera	Medical C	29a. Certifier (Chack only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examiner: On the basis of examination and/or investigation, in my opinion and on the basis of examiners and occurred at the time and the basis of examiners and occurred at the basis of examiners and occurred	e, and due to the or erred at the time, o	cause(s) and manner a late and place, and du	as stated. e to the cause(s)
/	To the comp	Me	29b. Signature and title of certifier 29c. License number	2	29d. Date signed (Mon	
			D0024184	(1ctober, 2	7,2009
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11. Date filed (Month, Day, Year) 32. Registrar's Signature	Hespital	(ol-nbi.	7, 2009 , Monthal 2104
	Sta Registr		31. Date filed (Month, Day, Yaar) NOV 0 2 2009 32. Registrar's Signature			

	1	For State Registrar	State of M	iai yiai i	-	rtificate o		aria ivie		Reg. No.	2009	35	503
		1. Decedent's Name (First, Middle, L	_ast)	_				2	. Date of Dea Month		Year	3. Time	of Death
hysician /Medical		Patri	icia S. Le	ahy				0	ctober		2009	5:35	A M
xaminer		a. Facility Name (If not institution, g	live street and numbe	r)		4b. City, Town	, or Location o	of Death		4c. (County of Deat	th	
		Montgomery Hosp				Rock\		27 Uro To	D. /- / D. //	M	ontgom	ery	
ral tor			Sex 7. A 1 □ M 2 X F		last birthday) Yrs.	Months Day		Min.	. Date of Birtl (Month, Day	n /, Year)	9. Bin	thplace (Star ountry)	te or Foreig
4	-	516-24-8236 Usual Residence of Decedent		84				56	eptember	11, 1	925 Min	nesota	a
1		10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside	City Limit
٥	013	Maryland Montgo	merv		Chevv	Chase						1 X 1Y	es 2□N
Funeral Director	Ē	10e. Street and Number	moly		Oncvy	10f. Zip Code	9			10g. Citiz	en of What Co	ountry?	
hy Funeral Director		600 Wisconsin Av	enue Apt	#1608		2	20815			Unit	ed Sta	tes	
l de	aue nue	11. Marital Status	12. Was Deceden Armed Forces	?	S. 13.	Was Decedent o	f Hispanic Ori uban, Mexicar	gin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)	1	 Race - Ame Black, White 		,
5		1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	If Yes, Give	_		1 □Yes 2 🛣 N	lo Specify:				Specify: TT		
00	20	15. Decedent's	Year or Dates	:	16a Dece	dent's Usual Occ	runation		1	16h Kin	W r of Business	nite	
tel C	Jei	(Specify only highest g	grade completed)		(Give	kind of work dor DO NOT use reti	ne durina mosi	t of working	Ì	100. 1011	id of Business	maustry	
Completed	5	Elementary/Secondary (0-12)	College (1-4or 4	5+)	Home	emaker	,			Ow	n Home		
BeC	מַ -	17. Father's Name (First, Middle, La	st)				18. Mothe	er's Name (/	First, Middle,				
	0	August Leroy S	Strand				Mo1	lie J	osephi	ne A	llen		
	W	19a. Informant's Name/Relationship	(Type. Print)		19b. Maili	ng Address (Stre	et and Numbe	er or Rural I	Route Numbe	r, City or	Town, State,	Zip Code)	
		Roy Douglas Stra	nd/Brother	c	6 Wh	elhouse	Wav.	Kitte	rv Poi	nt.	ME 0390)5	
		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of matory or other p	olace)	Dat	e	20c. Loc	cation - City or	Town, State	
		1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		P Arl Nat	ingto:	n Cemeter	.v	ovemb 200		Arli	ngton,	Virgi	nia
any injury or other traumatic once.	Ī	21. Signature of Funeral Service Lic	ensee	1,2,0,2	Ro	Name and Add	ress of Facilit	Fimera	1 Hame/I	Rether	da—Charn	7 Chace	Tnc
ă		John J. Vr	man	_M013	60 75	57 Wiscon	sin Aver	nue, Be	thesda,	Mary1	and 2081	4–3501	, LIIC.
		23a. Frt 1. Enter the disease, or co shock, or heart failure. List on	mplications that cause ly one cause on each	ed the death line.	n. Do not en	er the mode of o	lying, such as	cardiac or i	respiratory ar	rest,		Approxin Interval I	Between
n		Immediate Cause (Final disease or condition	9	Cereb	ral A	tery Oc	clusio	n			Ì	Onset ar	nd Death
1		resulting in death)	Due to (or a	s a consequ	uence of):								
r 		Sequentially list conditions,	b										
in e	2	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequ	uence of):								
Examiner	Ya	that initiated events resulting in death) Last	c Due to (or a	s a consequ	uence of):								
dical Examin	<u> </u>				,								
dical			d										
Physician/Me		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregna	ncy					2	3d. Date of de	liverv	
ician/Med	2	in the past 12 months? 1 □ Yes 2 ☒ No	1 ☐ Live birth 4 ☐ Pregnant	at time of d		☐ Ectopic pregna ☐ Other <i>(sp</i> ec <i>ify)</i>					Month	Day	Year
l s	2	9 ☐ Unknown	9 🗆 Unknown										
v Physic	۲ ۲	Part II. Other significant conditions	contributing to death	but not resu	ulting in the u	nderlying cause	given in Part I.		23e. Did to	bacco us	se contribute to	the cause	of death?
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pleted by									24a. Was a		24b. Were au	utopsy findin	gs availab
E O	5								autop perfor 1 🗆 Yes	med?	death?	completion of	or cause of
Be		25. Was case referred to medical					26. Place	of Death (Check only o		1 La Tes	5 2 1110	
1 100		examiner? 1 ∐ Yes 2 [X No	Hospital: 1 ☐ Inpa	tient 2 🗆	ER/Outpatie	nt 3 DOA	Other: 4 🗆 Nu	ırsing Home	e 5 ☐ Resid	ence 6	X Other (Spe	ecify) Hos	nice
		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of In (Month, D	jury Jav. Year)	28b. Time o Injury	f 28c. Ir	njury at /ork?		d. Describe h			1100	, p. L. C.
n: To	∄ │		ion	,,,,,,			□Yes 2□	No					
	alloll.	2 Accident investigati		njury - At ho	me, farm, str	eet, factory, offic	e	28	f. Location (S City or Tow	treet and n, State)	Number or R	ural Route N	lumber,
	IIIICalion.	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	28e. Place of li building,	sto. (Opcom)									
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l Certification: To	ical certification.	3 Suicide 4 Homicide 6 Could not determine	Physician: To the besaminer: On the basis	st of my kno	wledge, deat	h occurred at the	e time, date ar	nd place, an	nd due to the	cause(s) date and	and manner a	s stated.	se(s)
Certification: To	בחוכם	3 Suicide 4 Homicide 6 Could not determine 29a. Certifier (Check only one) 1	Physician: To the bes	st of my kno	wledge, deat tion and/or in	vestigation, in m	y opinion, dea	nd place, an	at the time,	date and	place, and due	e to the caus	
	בחוכם	3 Suicide 4 Homicide 6 Could not determine 29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best aminer: On the basis and manners	st of my kno	wledge, deat tion and/or ir	vestigation, in m	ny opinion, dea ense number	ath occurred	at the time,	date and 29d. Date	place, and due	to the caus th, Day, Year	r)
Certification: To	Medical	3 Suicide 4 Homicide 6 Could not determine 29a. Certifier (Check only one) 1	Physician: To the besaminer: On the basis and manners	et of my kno of examina stated.	tion and/or in	29c. Lice	y opinion, dea	ath occurred	at the time,	date and 29d. Date	place, and due	to the caus th, Day, Year	r)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 35039 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 29, 10:55 P M October 2009 James Harold Lawson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery if Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1X M 2 □ F 67 411-68-9220 August 24, 1942 Tennessee Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County ral", or items 23a or 28a-f show Examiner must be notified at 1 Tyles 2 □ No Maryland | Montgomery Gaithersburg Direct 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 20878 1072 West Side Drive United States death v Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔯
If Yes, Give
Year or Dates: 2**⋉** No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Saltimore, Maryland 21215-0036 Specify Specify: White þ 3 Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic event, the Medical and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 10 Owner/Operator Taxi 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Lawson Cecil Gilmore 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health Item 27 I Tina Jo Blackistone/Daughter 8354 Autumn Oaks Court, Chesapeake Beach, MD 20732 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If Ite any Injury or ot November 3, 1 Burial 2 □ Cremation 3 □ Removal from State Parklawn Memorial Park 2009 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 21. Signature of Funeral Service License Robert A. Pumphrey Funeral Home/Rockville, Inc. M01548 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis Hours /Medical Due to (or as a consequence of): Examiner Intracranial Hemorrhage Weeks Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Brain Metastasis Weeks burial-tra Due to (or as a consequence of) P.O. Box 68760. physician the use IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 Probabiy 4 ☑Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 sl performe 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 124 hours after death.

In Funeral Director: A sletely filled in by the fi 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Tasaod D67405 October 29, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland 20850 Sadia Masood, M.D. 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

		4	1 - State of Maryland / Department State of Maryland / Department Certification	nt of Health and N e of Death	Mental Hygid	ene 2009	35040
	Physicia	n/	1. Decedent's Name (First, Middle, Last) LONG		2. Date of Death Moath	Day Year	3. Time of Death / 9 3 2 M
	Medic Examin			Town, or Location of Death		4c. County of Death	
				oklyn	1	Baltimon	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 1 M 2 F 49 Yrs.	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, You Sept 28,	ear) 9. Birt Co. 1960 Mai	hplace (State or Foreign intry) cyland
	d tow		Usual Residence of Decedent				10d. Inside City Limits
	larylan 3a-f sh iified a	Funeral Director	WV Berkley Sprin	gs			1 ☐ Yes 2X No
	a or 28 be not	٥	10e. Street and Number 10f. Zi	p Code		g. Citizen of What Co	untry?
	th with ms 23 must	iner	94 Tri Lake Circle 2	5411		JSA	does Indian
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	þ	1 Never Married 2 Married 1 Vos 2 No	dent of Hispanic Origin? (Sp cify Cuban, Mexican, Puerto 2 X No Specify:	Rican, etc.)	14. Race - Amer Black, White Specify: Whi	e, etc.
15-0	72 hour "natu ledical	Completed	15. Decedent's Education 16a. Decedent's Ust (Specify only highest grade completed) (Give kind of we life. DO NOT us	ork done during most of worl	ting	6b. Kind of Business	ndustry
212	within giene.			,	f	ood indust	ry
bue	e filed trail Hyged ed oth	To Be			ne (First, Middle, Ma a Marie S		
aryle S	ould b			s (Street and Number or Rui			Code)
Ž,	nd 2 sh ealth a n 27 is eer trau			lin Avenue;			
Baltimore, Maryland 21215-0036	Page 1 al ment of H. ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🛣 Donation 5 ☐ Other (Specify)		Date 2	0c. Location - City or	Town, State
Balt	permit. Depart Import any inj		State Baltin	nd Address of Facility Anatomy Boar nore, Marylan			Street
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mo shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or endition resulting in death) a. Due to (or as a consequence of):	2	or respiratory arrest	t,	Approximate Interval Between Onset and
90	te be executed hysician and he burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last b. Due to (or as a consequence of). C. Due to (or as a consequence of):				
Box 687	law requires that the death certificate be executed as been signed by the attending physician and a 2 should be detached for use as the burial-transit	<u>e</u>	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of de Month	livery Day Year
ls, P.O.	uires that the signed by ald be detact	ρ	Part II. Other algrinount conditions contributing to death but not recalling in the directly in	cause given in Part I.	23e, Did toba	acco use contribute to	the cause of death?
of Vital Records,	law e 2	Completed			24a. Was an autopsy perform 1 Yes 2	prior to death?	topsy findings available completion of cause of
ital	Physician: The this certificate I	Be	25. Was case referred to medical examiner?	26. Place of Death (Che	1	- C - 21	
of V	g Phys er this neral di	te: To	I Impatient 2 Levoutpatient 3 Levoutpatient	28c. Injury at work?	28d. Describe how	nce 6 Other (Spec v injury occurred	siry)
ion	tendin leath. tor: Aft the fur	Certificate:	1	1 Yes 2 No	201 201		and Dougle Musels or
Division	al or At safter c I Direct d in by			ry, office	City or Town,	eet and Number or Ru State)	rai Houte Number,
L)	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Medical	29a. Certifier (Check 2 Medical Examiner: On the basts of examination and/or investigation, it only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred a conty one)	my opinion, death occurred	at the time, date and	place, and due to the	cause(s) and manner stated.
	To the within To the compl	Σ	29b. Signature and title of certifier	lc, License number	29	d. Date signed (Mont	h, Day, Year)
	•		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	DN43 FENSE HAA	twar A	NN APOLLI	MO21401
	Sta	te	31. Date filed (Month, Day Year)	LEINSE LIIM	14176		
	Registr		MOV 0 2 2009 Chair B. James				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 9 35041 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Doris R. Miller October 2009 5:50 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 16325 Frederick Road WOODDITE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | Aug. 24, 19 Carroll Birthplace (State or Foreign Country) 5. Social Security Number 1 □ M 2 🔀 F 214-20-1129 84 1925 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Woodbine Carroll 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 16325 Frederick Road 21797 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 Yes 2 1 ☐Yes 2 ☑ No Specify. white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wesley James Williams Mary Fanny Luthy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley Miller/spouse 16325 Frederick Road; Woodbine, Maryland 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ROTA 10 State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Pirt1. En er the disease, or omplication that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Calle (Final Intraces-eoral disease or con-resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con-quence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? LONAS 1 Yes 2 No 3 Probably 4 Unknown Hecovent UNO Seasis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ANatural 5 Pending 1 □Yes 2 □No investigation 2 Accident 6 Could not be determined

Examiner 68760. Ö ٦. Records. Vital of Division

Physician

Examiner

Funeral

Director

r than "natural", or Items 23a or 28a-f show the Wedlest Evaminar must be notified at

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filed within 72 hours after death with

1 and 2 should be Health and Mental

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permit. Pages 1 and:
Department of Health
Important: If Item 27
any Injury or other tr
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Physician

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funeral director.

filled in by

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Be Completed

Certification: To

ca

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

31. Date filed (Month

29b. Signature and title of certifier

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

02

32. Registrar's Signature

/Medical

death certificate be executed Hospital or Attending after death. Director: At within 24 hours a

249

#

State Registrar

DHMH 17 Rev 1/2001

mo

Main

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death

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J	U	14	4

Physic /Med Exami

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evanting must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,*

	-	For State of Maryland / Department of Health and Merital Hygiene 7 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3
sicia	n	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year
edica	al	Amel R. Menotti October 28, 2009 3:00 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
mine		3310 North Leisure World Blvd. #1022 Silver Spring Montgomery
rai tor		5. Social Security Number 6. Sex 1 Months 1 Mont
		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	ecto	Maryland Montgomery Silver Spring 1 □Yes 2 ☒ No
1		10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3310 North Leisure World Blvd. #1022 20906 United States
	Juera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
	Completed by Funeral Director	1 □ Never Married 2 Married 1 □ Yes 2 MNo 1 □ Yes 2 MNo Specify: Specify: White
	eted	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
	dwo	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Research Director Pharmaceutical
	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
	2	David Menotti Maria Menotti
		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13013 Boswell Court, Potomac, Maryland 20854
		20a. Method of Disposition 1 Darial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) November 2,
	-	4 Donation 5 Other (Specify) Montgomery Crematorium, Inc. 2009 Bethesda, Maryland
ouce		21. Signature of Funeral Service Licensee M01305 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850–2805
		23a. Pai 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final
an :al		disease or condition resulting in death) **Example 1.5
er	١	Sequentially list conditions, Bladder Cancer
	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C
	EX	resulting in death) Last Due to (or as a consequence of):
-	edic	d
	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) Month Day Year
Č	oy Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
	ted	1 _Yes 2 _No 3 _Probably 4 _XUnknown
.	ombie	24a. Was an autopsy findings available autopsy performed? death? 1 □ Yes 2 □ No
d	a B	25. Was case referred to medical examiner? 26. Place of Death (Check only one)
1	2	1 Yes 2 No
	icatior	1 Natural 5 Pending (Month, Day, Year) Injury Work? 2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 280 Place of Injury At home form attent forties of the continuous Countries of the continuous Research Countries Countries Countries Research Countries Countries Countries Research Countries
	ertit	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Medical Certification: To	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	Σ	29b. Signature and little of certifier D27786 D27786 D27786 D27786 D27786 D27786 D27786 D27786
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
State	e	Bernard Rogus, M.D. 3801 International Drive, #205, Silver Spring, Maryland 20906 31. Date filed (Month, Day, Year) 32. Registrar's Signature
istra		NOV 0 2 2009 Lever S. Bartel
1/200	01	ORIGINAL

Regist DHMH 17 Rev 1/2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 35043 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rita Mann Moscato 2009 РМ October 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Suburban Hospital</u> Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea May 31 1 **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 😿 F Days Hours 345-30-4329 ^{Country)} Germany Director 89 1920 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Kensington 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5012 Cushing Drive 20895 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Artist Art Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul Mann Martha Heydel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11708 Smoketree Road, Potomac, Maryland 20854 John J. Moscato/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 2. Mon Leonetery crematory or other place) 1 Durial 2 X Cremation 3 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 Cremătorium, Inc. Signature of Funeral Swice Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M00198 17557 Wisconsin Ave., Bethesda, 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Cellulitis, Sepsis, Dehydration disease or condition resulting in death) Medical Examiner Vascular Insufficiency Lower Extremities 1 year Ecquentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury for use as the bunal-trans <u>Hyperlipidemia</u> 50 years that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Dav signed by the aid be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed Chronic Alcohol Abuse 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has 1 🗆 Yes 2 🗆 No 1 🗌 Yes 2 😾 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To 1 XYes Other: 2 🗌 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32610 October 30, 2009 ss of person who completed cause of death (Item 23a) (Type, Print) CNamara, M.D. 10215 Fernwood Road, Bethesda, Maryland

Registrar DHMH 17 Rev 7/2009

State

Thomas McNamara, M.D.

31. Date filed (Mortin, Way, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Carmella T. Nowak October 27, 2009 ar 4:55 A.MM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 12/03/1921 Birthplace (State or Foreign Country)
 MO **Funeral** 1 □ M 2X F Months Days Hours Min. 214-16-6621 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Medical Examiner must be notified at Harford MD Bel Air 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1504 Stone Post Court 21015 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Specify White \$ Marylahd 21215-003 3 Nidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fii and Mental H Alfred Coriddi Mary Birgandi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Pages 1 and 2 st partment of Health an cortant: if item 27 Is r i injury or other traus Joan Sharesky - Daughter 1504 Stone Post Ct. Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department o important: if i 1 Burial 2 □ Cremation 3 □ Removal from State St. Stanislaus Cem. 10/30/2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore City 22. Name and Address of FacilitySchimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee 610 W. MacPhail Rd. Bel Air, MD 21014 Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence or death certificate be executed as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of). physician Physician/Medical attending IF FEMALE: use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) the 1 □Yes 2 □No 9 Unknown The law requires that the 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has t 24a. Was an autopsy After this certificate 2 No Vita 1 ☐ Yes 1 ☐ Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient ၉ 2 ☐ ER/Outpatient 3 ☐ DOA Division of filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 Natural death. 1 ☐Yes 2 ☐ No Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifies cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) မှ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Dr. State Registrar

09-08287 Jeffrey S. Neral

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 35045

		For State				Cert	ificate o	f Deati	7				Reg. No.	20	J U :		104
Physician/ edical Examine	1.	Jeffrey	S. No	eral								Date of Dea Month October 2	Day 25, 2009			Time of Death 1345 hrs	
	4	a. Facility Name (i Good Sama						4b. City, T Baltin	ore			. D (D		ounty of E		ace (State or	
Funeral Director		Social Security N		6. Sex		Age (In yrs. la:	st birthday) Yr	Month	r 1 Year S Days	Hours	Min.		5-1967	I F	orgian	y) PA	
d how any	1	Usual Residence of Decedent 10a. State											10	d. Inside City Yes 2			
the Maryland or 28a-f sh	1	0e. Street and Nu		Drive				10f. Zip	Code 2100	9			10g. Citize		Country	?	
or items 23s must be not	1	Marital Status Never Marri Widowed			Armed Ford Yes	dent Ever in U.s ces? 2X No	If 1	Yes, speci	fy Cuban, X No	Mexican, specify:	Puerto R			4. Race - A White, o pecify: W	etc.	n Indian, Black	ς,
ID 21215-0036 should be filed within 72 hours after and Mental Hygiers, 17: marked other than "natural", natic event, the Medical Examiner To Bo Commissed by	-	15. Decedent's Elementary/Second	ducation (Sp	ecify only hi	ghest grade College (1-4		16a. Deceded during	most of wo	rking life.	DO NOT I	ind of wo	ork done ed)		nd of Busin		County	
21215-0036 Juld be filed within 7 I Mental Hygiene. I marked other than ic event, the Medica	וע	7. Father's Name	•	e, Last)	4			.6 01.		8.Mother's	,	First, Middle Ranck					
MD 212 d 2 should be lith and Menta n 27 is marke aumatic even	1	9a. Informant's N	ame/Relation				333	Sull:	ivan	Driv		ural Route N bingd	on, M	D 210	009		
Baltimore, MI bernit. Pages 1 and 2 Department of Health a Important: If item 27 injury or other traum		20a. Method of Dis			Removal from	m State	Place of Disp crematory or laney	other place)	- 1	10-2	9-200		moniu	•	own, State	
Baltimo permit. Page Department of Important:	1	21. Signature of Fi	uneral Service	e Licensee			1 1	Inc 6	10 W.	Mac	Phai	1 Rd	Bel A	ir, N	1D 2	of Bel 1014 Approximate	
Physician Legi al xaminer		23a. Part I. Enter t failure. List of Immediate Cause or condition result	nly one caus (Final diseas	se on each li se a Mu	_{ne.} Itiple Inju			r the mode	of dying,	such as ca	ardiac or	respiratory	arrest, shoc	SK, OI HEAL		Between Ons Death	set and
		Sequentially list coif any, leading to icause. Enter Und	onditions, mmediate lerlying Caus	b Due		consequence c											
ecuted and - transit	Exa	(Disease or injury events resulting in	n death) Las	t Due		consequence o	of):										
760, cate be ex physician	sician/r	235. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy World 4 Pregnant at time of death 5 Other (Specify)								delivery Da	ay Y	ear					
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cords law requi	Completed											p	/as an utopsy erformed? es 2 N	p	Vere autorior to co leath?	opsy findings a empletion of ca	available ause of No
tal Rection: The certificate ector, page		25. Was case refe	erred to med	ical					26.Plac	e of Death	(Check	only one)					
n of Vital I	To Be	examiner? 1 ✔ Yes	2 No	Hos		npatient 2			DOA	Other ₄		ng Home 5	Reside	ence 6	Other:		
tending Pleath.		27. Manner of De1 Natural2 Accident	5 P	ending vestigation	28a. Date (Month Oct 25,	2009 (1000)	28b. Time 1254 hrs		1	ury at Wor Yes 2 ✔	No	Operator motor ve	of moto	rcycle t	hat co	llided with	
Division spiral or A tendii nour after ceath. nerra Director: /	Certification:	3 Suicide 4 Homicide	de	ould not be etermined	(Specify)	e of Injury - At I	eet					or Tov Old Harfo	vn, State) rd Road a	nd Wald	or Drive	e, Baltimore	
Div. To the Hospital of within 24 hour all Completely filled	Medical	29a. Certifier (Check only one) 2 2	/ Medical E	xaminer:0	: To the bes n the basis nd manner s	et of my knowle of examination stated.	dge, death o and/or inves	tigation, in	my opinio	n, death o	ccurred	at the time,	date and pla	ace, and c	ue to the	e cause(s) hth, Day,Year)	
	-		is.	N		se of death /Ito	m 23a)		0.0	.M.E.			Oc	tober 26	6, 2009) —————	
12V		30. Name and ad Ling Li, M		son who cor stant Med			n 23a) 1 Penn S	treet, Ba	ltimore	, MD 21	201						
Sta Regist	ate rar		onth, Day,Ye	A A D		egistrar's Signa	ature A.	San	de la								

09-08271 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Andrew Ndungu 35046 2009 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Physician/ 2304 hrs Medical Examiner October 24, 2009 4b. City, Town, or Location of Death 4c. County of Death Baltimore Good Samartian Hospital 9. Birthplace (State or If Under 24Hrs. Date of Birth (MM/DD/YYYY) If Under 1 Year **Funeral** 5. Social Security Number 7. Age (In vrs. last birthday) Months Days Hours Min Director 2 10d. Inside City Limits 10b. County Oc. City, Town or Location Yes 2 No hours after death with the Maryland Director 10g. Citizen of What Country Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Marital Status 12. Was Decedent Ever in U.S. Armed Forces? White, etc. Never Married 2 Yes Yes 2 No specify: Divorced Give Yea 2 16a. Decedent's Usual Occupation (Giva kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed ring most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Baltimore, MD 21215-0036 Be 20b. Place of Disposition (Name of cemetery, 2 Cremation Donation Other Specify Approximate Interval Between Onset and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. /Medical Death Acute pneumonia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X UNPENDED AMENDED 23a,PII,27,permE, g897 11/17/09 TT that the death certificate be Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23c. if yes, outcome of pregnancy 23d. Date of delivery Ectopic pregnancy Day Year Live birth Month Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions Division of Vital Records, P.O. contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 V No 3 Probably 4 Unknown Cardiomegaly Completed 24a. Was an After this certificate has been 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other₄ Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 Yes 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After completely filled in by the funera 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Certification: 1 X Natural 1 Yes 2 No 5 Pending Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

2 kg

State 31. Date filed (Month, Day, Year) 1009 Registrar's Signature

Deputy Chief Medical Examiner

Name and address of person
 Jack Titus MD. De

OOME

October 25, 2009

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

			For State Registrar	State of Ma	-	epartment of F Ce <i>rtificate of L</i>		Mental Hyg	iene _{eg. No.} 2009	35047	
	Physicia	n/	1. Decedent's Name (First, Middle, Las	,				2. Date of Death	h	3. Time of Death	
	Medic Examin	ai	Edith G		IIS	4b. City. Town, or	Location of Death		29, 2009 4c. County of Deatl	12:45 p M	
. 1	Examili	er	Gilchrist	,		Towso			Baltin		
	Funeral Director		5. Social Security Number 6. Security Number 106-26-6261	7. Age	(In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day 8/20/10		hplace (State or Foreign Intry) 'y land	
	od at	_	Usual Residence of Decedent 10a, State 10b, County		10c, City, Town o	or Location				10d. Inside City Limits	
	larylar 3a-f sl tified	Director	MD Balti	more	Parl	kville				1 🗆 Yes 2 🙀 No	
	a or 2	I Dir	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	-	
	th with ms 23 must	Funeral	8810 Walther Blvd			2123			U.S.A.		
36	after dea' Il", or iter xaminer	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give		If Yes, specify Cuba	Vas Decedent of Hispanic Origin? (Specify Yes or No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 N No Specify:		14. Race - Amer Black, White Specify:		
9-10	hours natura dical E	lete	15. Decedent's E			ecedent's Usual Occup			16b. Kind of Business		
21	hin 72 ne. than "	Completed	(Specify only highest gra Elementary/Seconday (0-12)	College (1-4 or 5-	F) Îli	Give kind of work done of fe. DO NOT use retired) egistered N	•	ang	Public Sch	100	
d 2	ed wit Hygie other i	Be C	17. Father's Name (First, Middle, Last)	3		egistered N		ne (First, Middle, M	System laiden Surname)		
ılan	d be fill Aental Irked of tic ev	ျာ	William A.	Harri	s		Bert		Bur 1	еу	
Mary	d 2 should be file alth and Mental I 27 is marked o or traumatic eve		19a. Informant's Name/Relationship (7)			Mailing Address (Street of New Street				Code)	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		20b. Place of E cemetery, Hillton	Disposition (Name of crematory or other place) Serv Corp	^{se)} 10/3	Date 80/09	20c. Location - City or Towson, M		
Balti	permit. Departr Imports any inji		21. Signature of Funeral Se Licens	^{ee} William	G. Dau	22. Name and Addres		uck Towso	n Funeral 21204	Home, Inc.	
١,	market and		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.	٨	2		or respiratory arre	st,	Approximate Interval Between Onset and Death	
	nysician Medical Examiner		disease or condition resulting in death)	a. Due to (or as a	cons uence of)	ky Disca	ŞC				
	od sit	Examiner	Sequentially list conditions, it any, reading to immediate cause. Enter Underlying	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)							
	icate be executed physician and s the burial-transit	al Exa	that initiated events resulting in death) Last	C. Due to (or as a	consequence of)	:			-		
760	cate by physic s the b	edical		d							
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. completed birector. After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE; 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d. Date of del Month	ivery Day Year	
P.O.	that the	by Ph	Part II. Other significant conditions of		it not resulting in	the underlying cause gi	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?	
ds,	quires en sign	ted t	Aortic Stenosi	\$				1 □ Y€	es 2 No 3 P	robably 4 🔀 Unknown	
Recor	The law reate has be bage 2 sho	Completed			·			24a. Was ar autops perform 1 \(\sum \) Yes 2	y prior to o ned? death?	topsy findings available completion of cause of	
tal	cian: 1 ertifica ector, p	Be	25. Was case referred to medical examiner?	Hoopital			ace of Death (Chec		734 110		
Ţ	Physia this cral dire	욘	1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospital: 1 Inpatie 28a. Date of injur		patient 3 DOA Oth ne of 28c. Injur	4 ☐ Nursing H	ome 5 Reside	nce 6 Other (Spec	in Hospice	
o uc	nding ath. r: After e fune	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,	Year) inju	ury work	Yes 2 No	Zod. Describe 110	w injury occurred		
Division	al or Atte s after des I Director d in by th	Certificate:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injurbuilding, etc.		n, street, factory, office		28f. Location (Str City or Town	reet and Number or Rui , State)	ral Route Number,	
	ne Hospit In 24 hour ne Funers pleted fille	Medical	(Check 2 Medical Exami	ner: On the basis of ex	amination and/or i	eath occured at the time nvestigation, in my opinion dge, death occurred at the	on, death occurred a	at the time, date and	d place, and due to the	cause(s) and manner stated.	
	To the contract of the contrac		29b. Signature and title of certifier	aut, CRN	f	29c. Licenso			9d. Date signed (Month October 29, 3		
			30. Name and address of person who of Marian Grant	completed cause of de	eath (Item 23a) (Ty	pe, Print) St, Tows	on, MD	21204			
	Sta Registr		Marian Grant, 31. Date filed (Month, Day, Year)	32. Registra	r's Signature	barlos					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Douglas Mathew Norris State of Maryland / Department of Health and Mental Hygiene 2009 35048 Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 27, 2009 Medical Examiner 1915 hrs Douglas Norris Μ. c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Pleasant Prospect Drive and Wood Lake Rd. Rowie 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or . Age (In yrs. last birthday) Funeral Months Days Hours Min. Country) S.C. Director 1 X M 2 250-82-0194 03/21/1950 Yrs Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No 28a-f show MD. P.G. Bowie once Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Examiner must be notified at 11724 Brookeville Landing Ct. 20721 U.S.A. 23a Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, death 7 Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2XX Married X Yes 1,69 Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after of Department of Health and Mental Hygene.
Department of Health and Mental Hygene.
Injury and I History and I have a present the man "natural", on Injury or other traumatic event, the Medical Examiner. Specify: Black Yes 2 X No specify. Divorced f Yes. Give Year Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Realtor Broker Private 1 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Ulysees Norris Dorothy Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 210 2102 ade) 19a. Informant's Name/Relationship (Type, Print) Kim F. Norris/Wife 11724 Brookeville Landing Ct. Bowie, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation Cheltenham Veteran 11/06/09 Cheltenham, Md. Donation 5 Other Specify Hackett s Funeral Chapel, Inc. 814 Upshur Street, NW DC 20011 21. Signature of Funeral Service License W 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva **Physician** failure. List only one cause on each line. Between Onset and /Medical Death Contact Gunshot Wound of Chest Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and ician/Medical UNPENDED AMENDED tending physician use as the burial Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Ectopic pregnancy Year Fetal death Month past 12 months? Pregnant at time of death Other (Specify) 5 icate has been signed by the att page 2 should be detached for 1 Yes 2 No 9 Unknown Unknown o Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Š σ. Yes 2 ✔ No 3 Probably 4 Unknown Completed Records, 24a. Was an 24h. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 No 1 🗸 Yes 2 No ector, 25. Was case referred to medical 26.Place of Death (Check only one) Be of Vital examiner? Other-DOA ġ. Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene this ဥ 1 V Yes funeral After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury Subject shot self Division Natural FOUND: hours after death.

uneral Director: // Yes 2 V No Pending Oct 27, 2009 1910 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 🗸 Suicide Could not be or Town, State)
Pleasant Prospect Drive and Wood Lake Rd, Bowie, MD determined (Specify) Parking Lot Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

the Hospital or Attending Physician; To the 1

29a. Certifier 1 29b. Signeture and title of certific

Medical

State Registrar

ec 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner

OCME

and manner stated

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

October 28, 2009

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

31. Date filed (Month, Day, Year)

Registrar's Signature

ORIGINAL

Physic	ian
/Medi	cal
Exami	ner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If flem 27 Is marked other than "nature." any hirry or other traumatic executions.

Physician

/Medical

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit more. P.O. Box 68760, Division of Vital Records.

State

Medical

29b. Signature and title of certifier

35049 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 29,2009 Month 3:30A Betty L. Peabody 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4240 Slater Avenue Nottingham Balto. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Months Days Hours Min 1 □ M 2 T F 216-28-6334 August 8,1932 Maryland Usual Residence of Decedent 10d, Inside City Limits 10a State 10h Counts 10c. City, Town or Location Funeral Director Md. Balto. Nottingham 1 ☐ Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 4240 Slater Avenue 21236 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Bace - American Indian. 11. Marital Status 1 Never Married 2 X Married Completed by If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank G. Michel Antoinette F. Vitek ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR 923 Delray Drive Forest Hill. Md. 21050 <u>Lesley E. Zaranski</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Hother (Specify) Entombment Gardens of Faith 11-2-2009 Balto. Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cen COLON disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes Certification: To

		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings availab prior to completion of cause of death? 1 ☐ Yes 2 ☐ No								
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 Yes 2	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	Home 5 Residence 6 □ Other (Specify)								
27. Manner of Death 1 Natural 5 Pending investigation	(Month, Day, Year) Injury Work? n M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred								
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	nysician: To the best of my knowledge, death occurred at the time, date and place, an niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.									

29c. License number

D27730

29d. Date signed (Month, Day, Year) Oct 29, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLET IT 569

31. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 29c, per DVR 9897 11/2/09 TT State of Maryland / Department of Health and Mental Hygien 2009 35050 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Yeer 4/41AM 164016 CTOPYER 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Health \$ Renab Cit Ellicott Howard Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 9 Days 250.14.362 Months Hours Min **Director** 30 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at MD Howard Woodstock Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Moline Court 21163 USA items 23a Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 Specify: Back 1 ☐ Yes 2 No Specify: δ 3 Widowed 4 Divorced naturel Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 72 Elementary/Secondary (0-12)

7 Arabe

17. Father's Name (First, Middle, Last) and Mental Hygiene. College (1-4or 5+) Federal Reserve Bank Guard permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any lighty or other traumatic event page. 18. Mother's Name (First, Middle, Maiden Sumame) Be Silas Pryor Mustopher Marting 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 4 Moline Court Woodstock MI Marion E. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/04/09 Owings Mills, MD 4 □ Donation 5 □ Other (Specify) Garrison Forest 22. Name and Address of Facility 21. Signature of Funeral Service Licensee avenn C. Greens Funeral sonts Roll Randallstown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death andiovaraler Dirase Immediate Cause (Final Physician Alher rolero la disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner lelero Vas Cerlas Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): as the burial P.O. Box 68760. physician Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an certificate has autopsy performed? 2 No 2 No 1 Yes 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospitel within 24 hours a To the Funeral I 15. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D30641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Back Rover Meck Road Balllowe Maylor 214 201-Sabapathy Kamech 109 2009 32. Registrar's Signature 31. Date filed (Month, Bay, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35051 Certificate of Death 2. Date of Death 2<u>009</u> Physician/ Month Kingsley Blake Price Oct 10:25p ^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice Towson <u>Baltimore Co</u> 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 8-24-1917 1 K M 2 D F Months Days Indiana 215-34-6419 92 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Unit Funeral East University Pkwy. 21218 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces' Black, White, etc. 1 🔀 Never Married 2 🗌 Married Completed by Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 K No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Professor Johns Hopkins Univ. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hildred Blake James Allen Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy Seifert - Attorney Eastern Blvd Suite C, Essex, MD 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 10-30-09 Baltimore, MD 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, MD 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year ed by the a P.O. cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CORONARY ARTERY DISEASE Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 N certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: in 24 hours after deaun. the Funeral Director: After this ce noleted filled in by the funeral dire 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) Residence 6 \(\text{M-Other} \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No. Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certif 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUR DOBERMANINO

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35052 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ PRUITT 18:24 PM LENE OCTOBEZ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER BAUTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1-30-1956 1 □ M 2 🗓 F Months Days Hours Min. 52 Director 214-72-6142 Maryland Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Ex-miner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Edgemere MD Baltimore Co. 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21219 7428 Blevins Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 2 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify. 3 Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Disabled N/A Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Murray Lee John Edward Pruitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7428 Blevins Avenue Edgemere, MD 21219 James Pruitt - Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State injury Bayview Crematory 11-3-2009 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Eunoral Service Licenses 22. Name and Address of Facility Kaczorowski Funeral Home, PA any 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ PULSELESS ELECTRICAL ACTIVITY mINS Medical resulting in death) Due to (or as a consequence of): **Examiner** CARDIAC ARREST 5 m. ~ 5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events POST GENERALIZED SEIZURE Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an autopsy performed' certificate I funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 5 Pending 1 Matural work? Accident
Suicide within 24 hours after death. To the Funeral Director: A 2 🗌 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and titl of certifier

Registrar DHMH 17 Rev 7/2009

State

68760

Box

Records,

Division of Vital

backs

RES-GOU

4940 EASTERN AVE BALTIMORE

123

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO, PhD 82. Regis ar's Signature

AGROR-ENOH

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - For State Registrar 35053 2. Date of Death 1. Decedent's Name (First, Middle, Last) October **Physician** 2009 Albert Pearsall 8:17 Raynor /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
March 10, 1925

9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours 1 X M 2 □ F 84 111-16-3042 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County if Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 X Yes 2 □ No Director Rockville Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20850 605 Blossom Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No WWT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 WWII 1 □ Yes 2 X No Specify: White ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Federal Government Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel Pearsall ပ Albert Benjamin Raynor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 647 Azalea Drive, Apt. #4, Rockville, Maryland 20850 Catherine L. Raynor /Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 3. permit. Pages
Department of
Important: If it
any Injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate Of Heaven Cemetery 2009 Silver Spring, Maryland 4 □ Donation 5 🕅 Other (Specify) Entombment Robert A. Pumphrey Funeral Hone/Rockville, Inc. 21. Signature of Funeral Service Licensee Inge lette Konsel 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiac Pulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner lor Attending Physician: The law requires that the death certificate be executed Acute Renal Failure ned by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Myelodysplastic Syndrome IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 □ Yes 2 □ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔯 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No Certification: To 27. Manner of Death 1 🕅 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral I To the Hospital 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number D0065505 Cha October 27, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QIUFANG CHENG m.D 9901 CENTER DR. ROCKVILLE, MD MEDICAL

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month,

32. registrar's Signature

State of Maryland / Department of Health and Mental Hygiene, 35054 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009 ear **Physician** October 28, 8:42 A^M Radner Zoel Mathew /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Min. March 9) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Year 1**X** M 2□ F 92 1917 Massachusetts Director 215-14-8153 Usual Residence of Decedent hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State or than "natural", or Items 23a or 28a-f show 1 X Yes 2 □ No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 20854 2294 Stratton Drive United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No WWII If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: Specify: Completed by 3 | Widowed 4 | Divorced 12 should be filed within 72 hc h and Mental Hygiene. 7 is marked other than "natur 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade comp (Give kind of work done during most of working life. DO NOT use retired) grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Systems Manager Business Machines 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental H Important: If item 27 is marked oth any Injury or other traumatic even Be William Radner Edvthe Hollop ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2294 Stratton Drive, Rockville, Maryland 20854 Radner / Wife Beatrice 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) November 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fairview Cemetery Westfield, New Jersey 2009 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service I Myselte M01305 ameli 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Parl 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiopulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Massive Gastrointestinal Bleed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner Physician; The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): inding physician ause as the burial Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atten for us 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a d be detached f 1 ☐Yes 2 ☐ No o 9 HInknown ٣. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 Hiatal Hernia, Esophagitis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performed? Yes 2 X No 1 ☐Yes 2 ☐No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred I or Attending F after death. Division 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifier Ma Than hubby D62562 October 29, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland 20850 Madhavi Hubbly, M.D. 31. Date filed (Month, Day, Year 32. Redistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2009 35055 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ramos 28, Nelson Rodriguez October P M 2009 1:10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Montgomery 9 Leonard Court Rockville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 X M 2 □ F 65 May 10, 1944 Director 213-41-2473 Venezuela Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ire Medical Examination on the profit of an once. 1 X Yes 2 □ No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9 Leonard Court 20850 Funeral Venezuela 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1XIYes 2□No Specify: Venezuelan If Yes, Give Year or Dates: Specify: Hispanic ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Professor Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Francisco Ramos Rosa Rodriguez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Fulton Street #802, New York, New York 10038 Andreina J. Ramos/Daughter 20b. Place of Disposition (Name of commetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Oct. 30, 2009 Bethesda, Maryland 21. Signature of Funeral Service Live see Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Haran Charlen M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Done Carcinomo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the death certificate be executed Exami signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown his certificate has been si director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an performe 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 □ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ie Hospital or Attendli 24 hours after death. e Funeral Director: A pletely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi Medical 2 Medical Examiner: Op the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier かつつチャ8 MOME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira N. Brecher, M.D. 2101 Medical Park Drive, #304, Silver Spring, Maryland 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 02 posto Registrar

ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 35056 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 1^{Day} **Physician** 2009 1:40 Chiona P. Reed /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Heartland of Hyattsville Hyattsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 6, Birthplace (State or Foreign Country)unk 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Months 1 □ M 21 € 493-46-3859 66 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any lighty or other traumatic event, the Medical Examination. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes & No Director Hyattsville MD Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6500 Riggs Road 20783 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status unk Black. White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: black 1 ☐ Yes 2 No 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heartland of Hyattsville 6500 Riggs Road; Hyattsville, Maryland 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 3 Removal from State 1 ☐ Burial 2 ☐ Cremation 4 □ Donation 5 🖾 Other (Specify) in State Fun al Service Licensee de State Anatomy Board; 655 W. Baltimore Street Mirector Baltimore, Maryland 21201 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immedia ause (Final disease or condition resulting in death) DIDPULMORAN **Physician** /Medical Due to (or as a consequence of): Examiner DCARDIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) attending physician i Division or Vital Records, P.O. Box 68760, Physician/Medical as the l IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has page 1∐ Yes 2 14 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient 3∏ DOA 2 □ FR/Outpatient ို After this 28a. Date of Injury (Month, Day Year) funeral 27, Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Injury 1 ☑Natural 5 Pending To the recent within 24 hours after dearn.

To the Funeral Director: At To the Funeral Director. At To the Funeral Director. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖫-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29h. Signature and title of certifier M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) polover 325A 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 per DVR g897 11/2/09 TT

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Scott October 3:20 AM 30 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Johns Hopkins City Hospital na If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Months 1 □ M 2 🗶 F 212-22-3249 Yrs. 86 3-31923 MD Director Usual Residence of Decedent 10b. County is 1 and a success are more than the first and Mental Hygiene.

I firem 27 is marked other than "natural", or items 23a or 28a-f show a real matic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State **x**Yes 2 □ No Directo MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21213 SA Ũ 1231 N. Ellwood Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏌 🗓 No Specify: Specify: Black 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) N/A Elementary/Secondary (0-12) 8th grade Sales Stewart's Dept 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Thomas Sheppard Susie ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto, MD 21213 Patrick Scott-Son N. Ellwood Avenue or other Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Important: If if
any injury or o ₩ Burial 2 Cremation 3 Removal from State 11-5-2009 Owings Mills, MD Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H mo1363 V C1-MD 21202 1101 E. North Avenue Balto, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Left middle cerebral artery cereprovascular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 3 No 1 □ Yes 2 = funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ■ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending al or Attendir s after death. investigation 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 ☐Could not be 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and tile of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 10/30/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shena-fu Lo Johns Hopkins Hospital 600 Wolfe St, Baltimore, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		•	State of Maryland / Department of H 1 - State Registrar State of Maryland / Department of H Certificate of D	ealth and Mental Hyg e <i>ath</i>	giene 2009 35058 Reg. No.
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	th 3. Time of Death
1	Medic Examin				18 ^{ay} 2009 1:00 p M 4c. County of Death
	<i>'</i>		4911 Goodnow Road Apt A Baltimo 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 1		N/A
	Funeral Director		212-62-7781 1 M 2X XF 56 Yrs. Months Days	Hours Min. 8. Date of Birth (Month, Day)	(Year) Country)
	show d at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	e Mary r 28a-1 notifie	Director	MD N/A Baltimore 100. Street and Number 10f. Zip Code		X Xves 2 □ No
	with th		10e. Street and Number 4911 Goodnow Road Road Apt A 2120		10g. Citizen of What Country? USA
980	within 72 hours after death with the Maryland glene. glene. er than "natural", or items 23a or 28a-f show, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 Never Married 1 Never No	panic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.) Specify:	14. Race - American Indian, Black, White, etc. Specify: Black
5-0	72 hours "natur edical	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done du	ion ring most of working	16b. Kind of Business Industry
Maryland 21215-0036	within 7 giene. ner than t, the M			đ	Disabled
and	교수들로	To Be		18. Mother's Name (First, Middle, I	Aaiden Surname)
aryli	2 should be file lith and Mental H 27 is marked o r traumatic eve	ľ		Mary Wood d Number or Rural Route Number,	City or Town, State, Zip Code)
Σ,	1 and 2 slot Health 8 item 27 i				alto, MD 21218
Baltimore,	permit. Page 1 and Department of Heal Important: If item any injury or other once.		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place King Memorial F	k 10-30-2009	
Balt	permit Depart Impor any in			^{of Facility} March Ea North Avenu	
	nysician/ Medical Examiner	er	Due to (or as a consequence of):	such as cardiac or respiratory arre	Approximate Interval Between Onset and Death
092	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours are death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical Examiner			
. Box 68	requires that the death certific been signed by the attending should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown No the past 12 months? 4 Pregnant at time of death S Other (specify) Other		23d. Date of delivery Month Day Year
ds, P.O	quires that the en signed by ould be deta	by	Fart II. Other significant conditions contributing to death but not resulting in the underlying cause give	n in Part I. 23e. Did to	bacco use contribute to the cause of death? Yes 2 Probably 4 Unknown
Division of Vital Records, P.O.	n: The law re- ficate has be rr, page 2 sho	Completed		24a. Was a autop: perfor 1 □ Yes	sy prior to completion of cause of
Vita	ysiciar is certii directo	To Be	examiner?	e of Death (Check only one) 4 Nursing Home 5 Reside	ence 6 Other (Specify)
n of	Jing Ph h After th funeral				ow injury occurred
ivisio	To the Hospital or Attending Physician: The law within 24 burus a red death for the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 or	Certificate:			reet and Number or Rural Route Number, n, State)
	e Hospita 124 hours e Funeral	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion only one) 3 Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the	death occurred at the time, date an	nd place, and due to the cause(s) and manner stated.
	To th withir To th comp	2	29b. Signature and title of certifier 29c. License	number 2	29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hevin Schender MD – 9114 Phyladel Phila (C	D. Suite 300	BACTO MD 21237
	Stat Registra		31. Date filed (Month, Day, Year) NOV 0 2 2009 2. Registrar's Signature		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician :36 AM 10 2009 /Medical 4a. Facility Name (If not institution 4b. City, Town, or Location of Death 4c. County of Death Examiner 19 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 6. Sex ate or Foreign **Funeral** 1 M 2 F Months Days Hours Min lohia, Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town of Location traumatic event, the Medical Exactions coust be notified at 1 Yes 2 No Funeral Director Illiamstown 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes 2 If Yes, Give Year or Dates 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Be ٩ (Street and Number of Rural Route Number nt's Name/Relationship 19b. Mailing Address permit. Pages 1 and Department of Healt important: If item 2: any Injury or other 1 once. 16/5 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 NOther (Specify) Enfombren Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially flot conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 5 Other (specify) the detached 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 XNo of Vital 1 ☐ Yes 1 Yes funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) Davyhters Other: 4 Nursing Home Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 🗷 Other (Specify) Home 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only To the 29c. License number 263 748

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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Jocelyne Toukep Kouatchou

hou,

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201 University Pkwy Baltimore Md 21218

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2009 35060 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** OCTOBER ^D2^y7,20^y6^a5 DMYTRO SHEVCHENKO 10:00 pM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FUTURECARE CANTON HARBOR BALTIMORE N/A 8. Date of Birth (Month, Day, Year)
DEC. 27,1925 UKRAINE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 6. Sex 9. Birthplace (State or Foreign Months Days **1X** M 2 □ F 215-30-7669 Director 83 Usual Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f shorevent, the Medical Exeminer must be notified at Director MD N/A 1X Yes 2 □ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 603 S. ANN STREET 21231 Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2 ☐ No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ENGINEER other t STRUCTURAL 17. Father's Name (First, Middle, Last) s 1 and 2 should be file f Health and Mental H tem 27 is marked oth Be 18. Mother's Name (First, Middle, Maiden Surname) N/A ဂ N/A 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REV. IVAN DORNIC/GUARDIAN 603 S. ANN STREET, BALTIMORE, MD. Department of Heal Important: If item 2 any Injury or other 21231 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) BAYVIEW CREMATORY 10/31/09 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22_Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anaemic Physician disease or condition resulting in death) Medical Due to (or as a consequence of): ∠xaminer Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of): Examiner The law requires that the death certificate be executed evebro. and Due to (or as a consequence of): physician a the burial-1 Box 68760. Physician/Medical attending p as IF FEMALE 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) ed by the detached ☐Yes 2☐No o 9 Unknown σ. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page Division of Vital 2 No 2 No 1 ☐ Yes 1 □Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No the within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide filled Hospital Medical 29a. Certifier Example 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) M.n 30. Name and the ress of person who completed cause of death (Item 23a) (Type, Print) altern Arenve stran 101 3023 31. Date filed (Month, Day, Year) State 0 2 2009 Registrar

Amend #7, 8, & 16b per AB G898 12/8/09 TT State of Maryland / Department of Health and Mental Hygiene 9 35061

			•	Cer	tificate of i	Death		Reg. No.	, 0)	33001
	Physicia		1. Decedent's Name (First, Middle, Last)	Stu	cker		2. Dete of D Month Octobe:		2009	3. Time of Death 11:30 PM
The second	/Medic Examin		4a Fecility Neme (If not institution, give street end humber)	0100		4b. City, Town, or L	ocetion of Dea		nty of Death	
N. Carlot	LXAIIIII		Future Care - Charles Village		В	altimore		Ва	ltimor	e
	Funeral Director		5. Social Security Number 220-36-1342 6. Sex 1 M 2 □ F 69 77	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Oct 27	irth 1939 Pay, Year) 1931	9. Birthe Cow Penns	olace (State or Foreign otry) sylvania
	pue *		Usuel Residence of Decedent 10a. Stete 10b. County 10c. City,	Town or Lo	cation				1	0d. Inside City Limits
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	vit vit	ᅙ	2141 Woodbox Lane #B		21209			USA		,
	leath	era	11. Maritel Stetus 12. Was Decedent Ever in U,S	. 13. V		lispanic Origin? (Sp	ecify Yes or N		ace - Americ	an Indian,
020	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Depertment of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any Injury or other traumatic event, the Medical Examiner must be notified at DRGs.	by Funeral Director	Armed Forces? 1 □ Never Married 2 ☑ Merried II □ Yes 2 ☑ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Detes:		f Yes, specify Cuba I□ Yes 2☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		lack, White, city: whit	
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₹	Men Men Brke etic	ို	Frank Stucker			Frances		-		
Mar.	end 2 sh salth end n 27 is m		19a. Informant's Neme/Relationship <i>(Type, Print)</i> Jolanda Stucker/spouse			and Number or Ru #B; Balti				
Baltimore, Maryland 21215-0020	Pages 1 on the nent of He int: if itam		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Cother (Specify) in state	ce of Dispos netery, cren	sition (Name of natory or other plac	ce)	Date	20c. Location	n - City or To	own, State
Balti	permit. P Depertmo importan any Injur pnice.		21. Signature (Fineral Se) vice Licensee, Diffector			ss of Facility Omy Board Maryland	-	W. Balt	imore	Street
		\dashv	23a. Pert1. Enter the disease, or complications that caused the death. shock or hear failure. List only one ceuse on each line.					arrest,		Approximate Interval Between
	Physician /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)		deme				-	Onset and Death
		lner		as a conseq	uence of):					
oʻ	icate be executed physician end s the buriel-trensit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a conseq	uence of):					
c 68760,	artificate be ing physici e es the bu	Medica	Cause (Disease or Injury that initiated events resulting in death) Last	es a consequ	uence of):	- 4;				
Box	ath ce ttend or us	an	0						1	
л О	v requires thet the death certific been signed by the attending p should be detached for use es	Physician	Part If. Other significant conditions contributing to death but not result	ing in the un	nderlying cause giv	en in Part I.		tobacco use		o the cause of death? bably 4 ☐ Unknown
Records,	The law requires thet the death certificate be executed the has been signed by the attending physician end page 2 should be detached for use es the buriel-trensit	Completed by					24a. We	s an autopsy formed?	av	ere autopsy findings ailable prior to impletion of cause death?
	he law e has	E					30	Yus 24 No	11	□Yes 2♥No
Vital	ificat or, p	Be C	25. Was case referred to medical			26. Place of Dea				
5	s cert direct	To B	examiner?	R/Outpatien	t 3 DOA Oth	05:		sidence 6 🗆 C	ther (Speci	(v)
o o	Hing Phy I. After this funeral o	Ilon: T	27. Manner of Death 1 ☑Naturel 5 ☐ Pending 28a. Date of Injury (Month, Dey Year) 2	28b. Time of Injury	28c. Injur Wor			how injury occ		,
Division of	i or Attanding Physician: after death. Director: After this certific d in by the funeral director,	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 1 ☐ Could not be determined 28e. Plece of Injury - At hom building, etc. (Specify)	ne, farm, stre				(Street and Number) Swn, State)	nber or Run	al Route Number,
	To the Mospital or Attanding Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	edge, deeth on end/or inv	occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time	e cause(s) and a, date and plac	manner as s e, and due t	stated. o the cause(s)
)	To the within 2 To the comple	M	29b. Signature end title of certifier		29c. Licens	BSIU2		29d. Date sig		
			30. Name end address of person who completed cause of deeth (Item :	590	Print) NUV(V	r ctal	19 56	rut B	altin	6, 2009 NOVEMANG
2	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrer's Signature NOV 0 2 2009	par	Yal .					\

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 35062 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2, 2009 **Physician** 2:30a M October Leo T. Stachowiak /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 345 Elrino Street Baltimore City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Dec 3, 7, 9, 9, 15 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland 93 212-07-2333 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show Yes 2□No Director Baltimore City Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with U.S.A. 21224 345 Elrino Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Mres 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2 M Married P Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Item any injury or other traumatic event, Item and once. Furniture Upolsterer 4th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosalie Jankowski Joseph Stachowiak 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7204 Bridgewood Drive Baltimore, Md. 21224 19a. Informant's Name/Relationship (Type. Print) Karen White (Friend) 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition October 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore,Maryland Holy Rosary Cem. 4 ☐ Donation 5 ☐ Other (Specify) 31,2009 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licens 1201 Dundalk Avenue Baltimore, Md.21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Africoscleratic cardiovascular ZO pecity **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending physical for use as the b 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 □Yes 2 🛛 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 30, 2009 D 37089 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Bruce Allen Leff, M.D. 5505 Hopkins Bayview Circle, Baltimore 212 24 2009³². Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 35063 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 28, Wen-Po Tsai 2009 1537 October 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday 1 M M 2 □ F 70 424-68-3289 July 7, 1939 Taiwan Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20878 United States 15 Turnham Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify Yes. Give Specify: Asian 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Scientist Biological Research 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hsing-Jia Tsai Ji-Tze Lin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Turnham Lane, Gaithersburg, Maryland 20878 Su-Huey Lan Tsai/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State November 7, 2009 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland Robert A. Pumphrey Funeral Home/Rockville, Inc 21. Signature of Funeral Service Licensee tte M01548 300 West Montgomery Avenue, Rockville, Maryland 20850 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Days Acute Respiratory Distress Syndrome disease or condition resulting in death) Due to (or as a consequence of): Days Sepsis Due to for ea a consectiones of Disseminated Intravascular Coagulation Weeks Due to (or as a consequence of) yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

physician and the burial-tran

attending pr

certificate has been signed by the rector, page 2 should be detached

funeral director,

filled in by

al or Attendi s after death. il Director: A

To the Hospital of within 24 hours and To the Funeral Completely filled

Medical Certification: To

Division of Vital Records, P.O. Box 68760

permit. Pages
Department of
Important: If It
any injury or o

Physician

/Medical

Examiner

Funeral

Director

iral", or items 23a or 28a-f sl Exeminar oust be notified

Pages 1 and 2 should be filed within 72 hours after rent of Heafth and Mental Hygiene.
ant: If Nem 27 is marked other than "natural", or lite aury or other traumatic event, I'm Michael Expansury or other traumatic event, I'm Michael Expansury

Baltimore, Maryland 21215-0036

death with the

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Funeral

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Completed

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Exami

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Physician/Medical IF FEMALE: Be Completed by

autopsy performed? 1 ☐ Yes 2 🖾 No 26. Place of Death (Check only one)

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes

25. Was case referred to medical aminer' 1⊠Yes 2 No 27. Manner of Death 1 🔼 Natural 5 Pending investigation

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 🗍 Homicide

1🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and titl Certifier

0

6 ☐ Could not be

determined

D62283

29c. License number

8600 Old Georgetown Road, Bethesda, Maryland 20814

29d. Date signed (Month, Day, Year) October 28, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. Keith Horvath, 31. Date filed (Month Day, Year)

32.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) OCTOBER 29, 2009 **Physician** 6:20 a^M MAGDALENA MARY TEMPLE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A FUTURECARE CANTON HARBOR BALTIMORE 8. Date of Birth (Month, Day, Year)
DEC. 26,1917 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🕱 F MARYLAND 212-28-8315 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Evancious roust be notified at 1 ☐Xes 2 ☐ No Director BALTIMORE MD N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21224 U.S.A. 316 N. ELLWOOD AVENUE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: \$ 3 ☑ Widowed 4 ☐ Divorced WHITE Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d 2 should be finith and Mental h Be N/A **GEORGE** RABB ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 Is n any injury or other traur TIMOTHY LINTZ, SR./GRANDSON 316 N. ELLWOOD AVENUE, BALTIMORE, MD. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition **X** Burial 2 ☐ Cremation 3 ☐ Removal from State PARKWOOD CEMETERY 11/3/09 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fundamental Signature Licensee ²² Name and Address Of Easility ER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, fram, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami physician and s the burial-trans men Due to (or as a consequence of) P.O. Box 68760 death certificate be Physician/Medical for use as attending IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy n the past 12 months? in the past 12, Month Day Ye ar 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has autopsy performed? Yes 2 No certificate 1 TYes Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Division 1 Natural Injury 5 ☐Pending 1 ☐Yes 2 ☐ No investigation death. 2 Accident after death completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Hospital or within 24 hours a 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0005517-1 M.D 0

Registrar

State

302

Eastern Avenue

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Stron

0 2 2009

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 35065 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1 0 Month **Physician** 3^{Day} ďg Rosetta A. Wright 5:35 p м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A Future Care Sandstown If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, 4 / 18 / 52 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Year) Days 1 □ M 2**X** F Director 212-58-1650 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show unt; If Item 27 is marked other than "natural", or items 2.0 and 10 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at MD N/A Baltimore 1 Tyles 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21205 USA 502 N. East Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status African Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify ੬ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Hospital Traveling Nurse 17. Father's Name (First, Middle, Last)
Jesse L. Wright, 18. Mother's Name (First, Middle, Maiden Surname) Be Idella Henderson Wright 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 244 2874 Scarbourgh Circle, Windson Mills, MD Lia A. Wright/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department of Important: If any Injury or once. Ardent Crematory 11/7/09 Hanover, MD 22. Name and Address of Facility Hari P. Close F. Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funer Service Senses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed aftending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) detached 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: ours after death.

eral Director: After this c Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide າ 24 hours a ne Funeral ໄ 156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hound to the second and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14 SICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1940 W. BALTIMORE ST. BALTIMORE, NO 21223 SANDHU MD 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 35066 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 27, 2009 6:50A. M Welzant Mary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Baltimore Gilchrist Hospice Care 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Jan 17, 1937 Maryland 72 213-34-9055 Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City. Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Baltimore Dundalk Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 U.S.A. 103 Center Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black White etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Johns Hopkins Elementary/Seconday (0-12) College (1-4 or 5+) Bayview Medical Ctr. 11th Medical Record Clerk permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other tany injury or other traumatic event, tingonea. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Stewart Rowland George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18612 Falls Road Hampstead, Maryland 21074 Marsha Hall (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20b. Place of Disposition (Name or cemetery, crematory or other place)

Oak Lawn Cemetery, 2009 1 Surial 2 Cremation 3 Removal from State Baltimore,Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee Avenue Baltimore Dundalk 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ YEARS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical as the t IF FEMALE: for use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death Day page 2 should be detached signed by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? CHRONIC KIONEY DISEASS 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pendina 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practioner: T. the best of my kin, wildge, death, occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certi 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

32. Resistrar's Signature

6701 NEHARLES ST, 8WITE 4105

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MD

31. Date filed (Month, Day, Year)

OCTOBER 27, 2009

BALTIMORE, MD 21204

		State of Maryland / [1 - State Registrar	Department of Health and M Certificate of Death	lental Hygie Reg	ene . _{No.} 2009 35067				
Physic /Medi		1. Decedent's Name (First, Middle, Last)	ch AUERBACH	2. Date of Death Month October	Day Year 3. Time of Death 18, 2009 7:00 A				
Exami Funeral		4a. Facility Name (If not institution, give street and number) 6237 Clearwood Road 5. Social Security Number 6. Sex 1 M 2 K F 64	4b. City, Town, or Location of Death Bethesda thday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	4c. County of Death Montgomery 9. Birthplace (State or Foreign Country)				
Director wou		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town		June 21,	1945 Washington, DC				
ith the Mar or 28a-f sl	Director	10e. Street and Number	Bethesda 10f. Zlp Code		1 □ Yes 2 ☒ No i. Citizen of What Country? Inited States				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational booling and page.	Funeral	6237 Clearwood Road 11. Marital Status 1 □ Never Married 2 ☑ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give X	20817 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc. Specify: White				
rithin 72 hours ne. han "natural"	Completed by	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. Do NOT use retired) domemaker		Sb. Kind of Business/Industry Own Home				
ald be filed w fental Hygier rked other ti	To Be Cor	17. Father's Name (First, Middle, Last) Harold Lester Hi	18. Mother's Name	e (First, Middle, Ma Ose Kirso	iden Surname)				
and 2 shou and 2 shou saith and N 27 is mai			o. Mailing Address (Street and Number or Run 237 Clearwood Road, B	ethesda,	MD 20817				
Pages 1 Iment of Hitant: If iten		1 1 Burial 2 □ Cremation 3 to Removal from State 4 □ Donation 5 □ Other (Specify) King [f Disposition (Name of ry, crematory or other place) David Memorial Garden		oc. Location - City or Town, State Palls Church, VA				
permit Depar Impor any in		21. Signature of Fulgral Service Licensee # M01008	22. Name and Address of Facility Torchinsky 1 Hebrew F						
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Signet Ring Ce Due to (or as a consequence)	ell Cancer - Metastat		Interval Between Onset and Death 23 Months				
E.R.	dical Examiner	Sequentially list conditions, if any hearth of the form as a consequence o							
the death certific y the attending p ched for use as i	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	a 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year				
w requires that the d s been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting I Hypertension	n the underlying cause given in Part I.		cco use contribute to the cause of death?				
The law recate has bee	Completed	Uterine Cancer Diabetes	·	24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ation: To Be		Other:	h (Check only one) ome 5 AResiden 28d. Describe how	ce 6 Other (Specify)				
ital or Atte urs after der ral Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)		City or Town,					
To the Hosp within 24 hou To the Fune completely fi	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledg 2 Medical Examiner: On the basis of examination and manner stated.	nd/or investigation, in my opinion, death occur	rred at the time, da					
15 or 5 with	2	29b. Signature and title of certifier	29c, License number D 005788		October 19, 2009				
C+	ate	30. Name and address of person who completed cause of death (Item 23a) Damein T. Doyle, M.D. 1801 F. Jef 31. Date filed (Month, Day, Year) 32 Registrar's Signature	ferson St., Rockvill	e, MD 20	08.52				
Regist		OCT 2 0 2009 /2 man B.	barked						

State of Maryland / Department of Health and Mental Hygiene 35068 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 14, 2009 ar **Physician** 11:00P. M JESSE EUGENE ALLEN, SR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Woodbine 5934 Woodbine Road, Lot33 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 30,1232 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ★M 2 □ F Washington, DC 214-28-9931 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Carroll 1 ☐ Yes 2 No Director Woodbine with the 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 21797 United States 5934 Woodbine Road, Lot33 or items 23a Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give 1953-1961 Year or Date 1953-1961 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: þ White 3 Widowed 4 Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Private Plumber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Hinton Clifford R. Allen permit. Pages 1 and 2 s.
Department of Health an.
Important: If item 27 is m.
any injury or other 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5934 Woodbine Road, Lot33 Woodbine, Maryland 21797 Mary Ann Allen -wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 10/19/2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bonard O' Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 reld 1500 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Coronary Heart Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the critical Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of) Box 68760 Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) P.0. signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 sl 24a Was an autopsy performed? 1 □ Yes 2 X No the Hospital or Attending Physician: The certificate 1 ☐Yes 2 XNo 25. Was case referred to medica director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After thi funeral of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred ospital c.
4 hours after dean...
- real Director Aftr 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 🗴 C rt fying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check on wed al Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature 29c. License number 29d, Date signed (Month, Day, Year) 2 D434235 6+1 30. Name and ad control erson who completed cause of death (Item 23a) (Type, Print) Mohit Narang, M.D. 555 South Center Street Westminster, Maryland 21157 31. Date filed (Month, Day, Year) 22. Registrar's Signature State OCT 2 0 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 35069 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 0235M Ethel Pearl Ashenfelter 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Havrede Grac Harford tizons nursina Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs Months Days Hours Min Date of Birth (Month, Day, Y an. 10, . Age (In yrs. last birthday) ^{Year)}922 Days 1 ☐ M 2**V**☐ F 226-12-0545 87 Jan. Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Harford Aberdeen 1 ☐ Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 809 Randolph Drive U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Twelve Years College (1-4or 5+) Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry C. Hartley Bessie White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilda G. Ashenfelter 809 Randolph Drive, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hopewell Cemetery 10/23/09 Port Deposit, Maryland 21. Signiture of Funeral Service Licensee Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 Soas ONO an 10 disease or condition resulting in death) Due to (or as a cons a uence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a nonsequence of) Due to (or as a consequence of): 23d. Date of delivery

Day

Year

Month

29d. Date signed (Month, Day, Year)

109

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

a or 28a-f show t be notified at

ms 23a

"natural", or Items

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marked (

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any linjury or other traumatic evone.

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit been signed by the atte should be detached for After this certificate has funeral director, page 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica filled in by the funeral director,

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Asinenfetter, Ethel

V9

Examin Physician/Medical Completed by Be Medical Certification: To

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Sursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

31. Date filed (Month, Day,

uram

29b. Signature and title of certifier

Kamman

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

MA

29c. License number

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9

			For State Registrar	State of Marylan	nd / Depa <i>Cei</i>	artment of F	lealth and N Death		iene2	009	350	70
Г			1. Decedent's Name (First, Middle, Last) 2. Date of Death							Year	3. Time of De	eath
П	Physici /Medic Examin		AUBREY EUGENE BEC		October	16,	2009	17:51	М			
			4a. Facility Name (If not institution, give	4b. City, Town, o	1	4c. County of Death						
			Shady Grove Adven	Rockvill		Montgomery						
	Funeral Director		5. Social Security Number 6. Se X	ex 7. Age (In yrs. 71	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 3/20/38	Year)	9. Birthp Cour MD	place (State or I ntry)	Foreign
	pr ,		Usual Residence of Decedent	100 0	ty. Town or Lo	antina				1	0d. Inside City	Limite
	aryla shov	5	10a. State 10b. County	100. Cit	ty, TOWITOT LO	cation				'	1 ☐ Yes 2	
	28a-f	Director	MD Montgame	ry Ger	rmanto	VID 10f. Zip Code		- 1	Oa Citizon	of What Cour		
	with t	ä	10e. Street and Number	11.00 July 1		20874			USA	OI WHAT COU	, ii y s	
	should be filed within 72 hours after death with the Maryland and Mental Hyglene. I marked other than "natural", or items 23a or 28a-f show umatic event, the Fodical Expriment was the profibed at	eral	20013 Sweet Gum C	12. Was Decedent Ever in U.	S 13		lispanic Origin? (Si	necify Yes or No-		Race - Americ	ean Indian.	
		Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)		Black, White,		
936	al", or	by				1 ☐ Yes 2 📉 No Specify:			Specify: Black			
21215-0036	2 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kin (Specify only highest grade completed) (Give kind of work done during most of working						16b. Kind	ind of Business/Industry		
21	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)					
2	ed wi	ပ္ပ	12		Porte	er			Hous.			
ğ	be fill d oth even	To Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, N Rockwi + k		name)		
<u> </u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modical Examination and page.		unk Dorothy Beckwi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Num									
Baltimore, Maryland			19a. Informant's Name/Relationship (7) Winifred E. Beckw			3 Sweet G			•			74
ē,			20a. Method of Disposition	20b. F		osition (Name of matory or other place				ion - City or To		
ē			1 ☐ Buriat / 2 D Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemoval nom siane	11)	20/09	Hano	ver, M	-	
薑	ortar injur		21. Signature of Funeral Service Licen		dent C	rematory 2. Name and Addre		nowden Fi				
Ö	Depared Important and in poore		Acolar,	Just	$-\lambda_2$	46 N. Was					0850	
	Attending Physician: The law requires that the death certificate be executed by redeath. The death. The death are perfectly a second of the attending physician and cector. After this certificate has been signed by the attending physician and cector. After the funeral director, page 2 should be detached for use as the burial-transit as the burial-transit.	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Anoxic ence Due to (or as a consect b. Respirator Due to (or as a consect c. Pneumonia Due to (or as a consect d.	quence of): y fail: quence of):							
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P.O. Bo)	uires that the death certiffices signed by the attending is detached for use as	Physician/Medical	23c. If yes, outcome of pregnancy in the past 12 months? 1						23d. Date of delivery Month Day Year			
σ.		y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobar							cco use contribute to the cause of death?		
2	quire; an sig uld be	q pe	Hypernatremia						1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown			
ပ္က	e iaw requir has been s ie 2 should I	Completed by						24a. Was ai		24b. Were autopsy findings available prior to completion of cause of		
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ita	clan: ertific	Be	25. Was case referred to medical examiner?	Hospital:				ath (Check onl on				
-	this c	မ	1 ☐ Yes 2 🕅 No	nt 3 DOA Oth		e 5 Residence 6 Other (Specify)						
Ĕ	ling F	ion:	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1			28d. Describe how injury occurred					
Division of Vital Records,	il or Attending Physician: The lafter death. Director: After this certificate hid in by the funeral director, page	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, strubuliding, etc. (Specify)			eet, factory, office 28f. Locat			tion (Street and Number or Rural Route Number, or Town, State)			
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in It	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	vithin 2 To the		29b. Signature and title of certifier	29c. License number			29d. Date signed (Month, Day, Year)					
	5		Machan Hubby MD			D62562			10/19/09			
	-3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
			Madhavi Hubbly,			Dr, Rock	ville, M	D 20850				
	Sta Registi		31. Date filed (Month, Day, Year)		Anna	12.5						

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 4:13 aM Nevart Rean October 14, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Holy Cross Hospital Montgomery 5. Social Security Numbe If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min Director 032-05-2819 91 December 01,1917 Massachusetts Usual Residence of Decedent 10c. City, Town or Location Show 10a. State 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 K No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with Health and Mental Hygiene.
em 27 is merked other than "natural", or items 23a or 14 Aylesbury Court 20905 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 If Yes. Give 1 ☐Yes 2 X No Specify: 2 Specify: 3 Widowed 4 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Bedros Torokhanian Ida Sarmanian 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacey Pariseault - Niece 8452 Early Bud Way, Laurel, Maryland 20723 Peges 1 arent of He 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 BRemoval from State 4 Donation 5 Dother (Specify) Woodlawn Cemetery 10/21/2009 Everett, Massachusetts 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Day Pneumonia /Medical Due to (or as a consequence of): Examiner Dementia Yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Sepsis and Day buriel-tra Due to (or as a consequence of): physician Box 68760 Physician/Medical the attending p IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 5 Other (specify) P.O. the 9 Unknown à signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate Division of Vital 2 X No 1 ☐ Yes 1 ☐ Yes 2 ☐ No After this certification, funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 X Natural 5 Pending n 24 hours after death.

le Funeral Director: A
pletely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Sulcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifie (Check only one) To the within 2 and manner stated. ture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 D50987 10/15/09 Name and address of person who completed cause of death (Item 23a) (Type, Print) SPRING MO 20910. 1500 FOREST GLEN RD SILVER AHMED NAWAZ 31. Date filed (Month, Day, Year) /32. Registrar's Signature State 2 0 2009 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend #1 & 2 per MD 889/ 11/10/09 Tr State of Maryland / Department of Health and Mental Hygiene

2009 35072 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Phyllis Baron 2. Date of Death 16 3. Time of Death **Physician** Phyllis J. October 15 200^{Year} /Medical 10:00 AM 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1300 Alderton Lane Silver If Under 1 Year Spring If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1 M XXF Months Days Hours Min Director 545-62-4540 Usual Residence of Decedent June 5, 1946 New York 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f show 10d. Inside City Limits event, the Medical Examiner must be notified at Director MD Montgomery Silver Spring 1√2 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with I Hygiene. by Funeral 1300 Alderton Lane 20906 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 💆 No Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Attorney Legal s 1 and 2 should be filk if Health and Mental Hi item 27 is marked oth 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ျှ <u>Jack</u> Cook <u>Harriet</u> Ouartin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Frank Witebsky, Husband 1300 Alderton Lane. Silver Spring, MD 20906 permit. Pages 1 a Department of Hei Important; If item any Injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) Parklawn Mem. Park 10/21/2009
22. Name and Address of Facility Danzansky Rockville, Maryland Goldberg Memorial Chapel, INC. 21. Signature of Funeral Service Licensee W01477 1170 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Small Cell Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 ☐ Yes 2 🛣 No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe has 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 □Yes 2 No 1 ☐ Yes 2 🖾 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending the Funeral Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Wardy B. Bernsten, MD 35 MO 040668E (PA) october 19, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wendy B. Bernstein, M.D. 8901 Rockville Pike, Bethesda, Maryland 20889 31. Date filed (Month, Day, Year) 2. Registrar's Signature State acked OCT 20

DHMH 17 Rev 1/2001

Registrar

	1	For State of Registrar	Maryland /	Depa Cer	rtment of Ho tificate of D	eain	Reg	ene 2009	
Physician /Medical	1	Decedent's Name (First, Middle, Last) Kenneth Esau Bisho	p			00	Date of Death Month	Day Year 10, 2009	3. Time of Death 5:00 A M
Examiner	ı		tation C		4b. City, Town, or Silve	Spring	Date of Birth (Month, Day, Y	4c. County of Death Montgome 9. Birth Cou	
Director	į	243−38−5062 Page M 2 F Supply	79	Yrs.	Months Days		v. 29,	1929 Nort	h Carolina
Maryland a-f show		0a. State 10b. County Maryland Montgomery	10c. City, T		pring				10d. Inside City Limits
3a or 28	1	0e. Street and Number 901 Arcola Avenue			10f. Zip Code 20902			Dritzen of What Cou United Sta	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show minportant: if item 27 is marked other than "hatural", or items 23a or 28a-f show pinportant: if item 27 is marked other than "natural", or items 23a or 28a-f show amply injury or other traumatic event, if a Modeal Exam, inc. inst ba notified at once. To Be Completed by Funeral Director		11. Marital Status 1 Merital Status 1 Merital Status 1 Merital Status 1 Merital Status 12. Was Decernate For 1 内容 For 1 has 1 h	2 □ No e		Vas Decedent of His Yes, specify Cubar □Yes 2⊠No	spanic Origin? (Specify, Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - Ameri Black, White, SpecifyAfri	
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uld be filed w Mental Hygie arked other t atic event, III To Be Co		17. Father's Name (First, Middle, Last) Esau Bishop			Dellimen	18. Mother's Name (F			
od 2 shou lith and N 27 is mar r traumat		19a. Informant's Name/Relationship (Type. Print) Constance Bishop Woody	/Sister	19b. Mailin 4338	g Address (Street a	nd Number or Rural F Cerrace, SI	Route Number, 6 E Washin	City or Town, State, Zongton, DC	ip Code) 20019
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iclan certifi ector	מ	25. Was case referred to medical examiner? 1 □ Yes 2 🏋 No Hospital: 1 □	Inpatient 2 ☐ E	R/Outpatie	nt 3 DOA Oth	er: 4 Nursing Home		nce 6 □Other <i>(Spe</i>	cify)
Attending in death. ector: After by the fune fine fine fine fine fine fine fine fi	I IIII CAIIOII. I	2 Accident investigation 3 Suicide 6 Could not be 28e. Place	th, Day, Year)	28b. Time of Injury ne, farm, st	Wor	ć? Yes 2□No		w injury occurred reet and Number or Ri , State)	ural Route Number,
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To the Hosp within 24 hou To the Fune completely fil	Med	29b. Signature and title of officer	le		29c. Licens	e number	29	October 16	h, Day, Year)
2 4		30. Name and address of person who completed cau Barry N. Rosenbaum, M.I	se of death (Item :	23a) (Type Farra	gut Avenu	e Kensingt	on, MD	20895-2110)
State Registrar		31. Date filed (Month, Day, Year) Seneral 32. F	Registrar's Signatu	ire Ked					

1 - For State Registrar

			1. Decedent's Name (First, Middle, La	st)						2. Date of Deatl			3. Time	of Death
	Physicia		Sina Paulir	ie Brown					1	Month October	Day O	Year	7:	16 AM
	/Medic		4a. Facility Name (If not institution, given	(o street and number)		4b City T	Fown or	Location of	of Death	october		County of Death		
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	Funeral		5. Social Security Number 6. 9	Sex 7. Age (In yrs. k 1 □ M 2 💢 F 87	as <i>t birtno</i> aj Yrs.		Days	Hours	Min.	Date of Birth (Month, Day,	Year)			e or Foreign
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ă	permit. Pages Department of Important: If It any Injury or one		> Khuld F	to not								on, DC		
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			23a. Part Lenter the disease, or conshock or heart failure. List only									/	Approxim Interval E Onset an	Between and Death
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1	/Medical		resulting in death)	Due to (or as a consequ										
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ם מ	eath attel for u	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d	death 3	B □ Ectopic pr 5 □ Other (s <i>p</i> e	regnancy	У				Month	Day	Year
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DIVISION OF	Ing .	ou	27. Manner of Death 1	28a. Date of Injury (Month, Day, Year)	28b. Time Injury	/	8c. Injur Worl	k ?		28d. Describe ho	ow injury	occurred		
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\equiv	r Atl	ţį	3 ☐ Suicide 6 ☐ Could not to determined		me, farm, :	street, factory,	, office			28f. Location (Since City or Town	treet and n, State)	Number or Run	al Route N	umber,
5	talo alDi edir	Certification:								,	, ,			
	To the Hospital or Attending Physician: The law requires that the dividing L4 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached		29a. Certifier 1 Certifying P	hysician: To the best of my know	wledge, de	ath occurred	at the tir	me, date a	nd place,	and due to the o	ause(s)	and manner as	stated.	-(a)
	n 24 n 24 ne Fi	Medical	one)	miner: On the basis of examina and manner stated.	tion and/or	investigation,	, in my d	pinion, dea	ath occur	red at the time, t	зате апо	place, and due t	o trie caus	e(s)
	Vithii To th	ğ	29b. Signature and title of certifier			29c.	. Licens	e number		2		e signed (Month,		7)
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7			30. Name and address of person who	completed cause of death (Itam	23a) (Tue							_		
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		to.	9	32. Registrar's Signa	tune			1008	010	1 /	10	2005		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009

35074

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35075 Reg. No 2009 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** OCTOBER 14, 2009 0905 JEROME BRYAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex Funeral Hours Min 11☑ M 2□ F Months Davs Director 87 1/25/1922 Washington, DC 578-18-7016 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at txTxYes 2 □ No Director DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3009 O Street SE 20020 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: Black þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Government Cash Vault Supervisor permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If Item 27 Is marked other t any Injury or other traumatic avant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John A. Bryan Sr. Ruth Lloyd ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolph Torrence /Nephew .0904 Sutton Drive. Upper Marlbor, Maryland 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/20/2009 Laurel, Maryland Maryland National 22. Name and Address of Facilitalexander S. Pope Funeral Home 21. Signature of Funeral Service Lice 1401083 2617 Pennsylvania Ave. SE Washington, DC 20020 23a. Part 1 Enter the disease or com shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a SEPTIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DEHYDRATION Sequentially list conditions, to ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of executed CLOSTRIDIUM DIFFICILE COLITIS and burial-trar Due to (or as a consequence of) Box 68760. attending physician law requires that the death certificate be Physician/Medical the asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a ☐Yes 2☐No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2X No certificate 1 ☐ Yes 2X No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 ☐ Yes 1 Xinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 24 hours after death.

Funeral Director: After this completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifie 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number 10/14/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nabila Khan 1500 Forest Glen Road Silver Spring, Maryland 20910 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35076 Reg. No. 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death october 15, 2009 **Physician** 6:55P M Beasley William Osby /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Burtonsville Montgomery Sanctuary at Holy Cross If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) | Sep • 23, 1934 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 € M 2 □ F Virginia 228-42-1899 75 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show r than "natural", or Items 23a or 28a-f sho the Medical Examiner must be notified at Prince George's Beltsville 1 ☐ Yes 2 X No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4608 Josephine Avenue 20705 United States Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23, any Injury or other traumatic event, the Modical Examiner must Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No White Specify: Specify: 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stone Mason Masonry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert Grover Beasley Ellie Mae Breeden ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Deana J. Cleary -daughter 4608 Josephine Avenue Beltsville, Maryland 20705 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Union Cemetery 10/20/2009 Burtonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bonald Vices Bofg Wardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 0.13 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** End stare COPD disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has tirector, page 2 s autopsy perform 2 🔀 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Funeral Director: / completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

3

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Sunitha Bhogavilli, M.D. 9801 Georgia Avenue, #117 Silver Spring, Maryland 20902

29c. License number

D54566

29d. Date signed (Month, Day, Year)

October 16, 2009

and manner stated

82. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35077 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Magdaline Becka October 2009 3:20 AMMedical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 4814 Osage Street Prince George's College Park Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Smock, PA 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Days (Month, Day, November Hours Min 1 🗆 M 2 🖾 F 193-10-6039 95 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Maryland Prince George's College Park 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 4814 Osage Street 20740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. <u>ک</u> 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: "natural", 3 X Widowed 4 Divorced Specify: White Completed Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Я Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H of Health and Mental H fitem 27 is marked ot Albert G. Mesaros Mary T. Misenko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Becka / Daughter 15316 Arbory Way, Laurel, MD 20707 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State permit. Page Department of Important: If any Injury or Gate of Heaven Cemetery | 10/23/2009 | Silver Spring, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. RAY Regens . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a, Part 1 Approximate Interval Between shock, or heart failure Immediate Cause (Final Onset and Death Physician/ Pulmonary Hypertension disease or condition resulting in death) 20 Years Medical Due to (or as a consequence of) Examiner Pulmonary Fibrosis Sequentially list conditions Examine Qui to for as a consequence of cause. Enter Underlying sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury Chronic Obstructive Lung Disease that initiated events resulting in death) Last Due to (or as a consequence of) ending physician use as the burial-Physician/Medical Cardiomyopathy P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No for Day Month Year 5 Other (specify) Pregnant at time of death the ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Congestive Heart Failure 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed' death? 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🖾 Residence 6 🗍 Other (Specify) 1 Yes 2 🛛 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death nours after death.

neral Director; After the filled in by the funeral Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural 5 Pending 2 🗆 No 2 Accident
3 Suicide 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hound to the second (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29b. Signatur Date gigned (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

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ORIGINAL

Vernon C. Smith, 5223 Georgia Avenue, NW, Washington, DC 20011

32: Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

OCT 2 0 2009

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra AMEND#3, 29 Cheen MD, 10-20-2009, BW, McConcertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $7:34 \frac{m}{a}$ **Physician** 10 10 2009 Charles W. Cushion /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner National Naval Medical Center Bethesda, Maryland Montgomery 8. Date of Birth (Month, Day, Yea, Anril 22, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year) Days Months Hours Min. 1√2 M 2□ F 524-52-4307 67 Director 1942 Iowa Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examinar must be notified at 1 ☐Yes 2 NO Directo Virginia Fairfax Fairfax 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 12220 Ox Hill Road 22033 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?
 1 X es 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 XYes 2 No
If Yes, Give
Year or Dates: 1966-1992 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify. þ 3 Widowed 4 Divorced 'natural", Completed 16b. Kind of Business/Industry the Medical Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Institute for Elementary/Secondary (0-12) College (1-4or 5+) Administrative Officer Defense Analyses 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental Clyde Cushion ၀ Helen Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy L. Cushion - Wife 12220 Ox Hill Road Fairfax, VA 22033 permit. Pages t and 3 Department of Health Important: If item 27 any Injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat'1 Cem. 12/16/2009 4 Donation 5 Dother (Specify) Arlington, Virginia 22. Name and Address of Facility EVERLY FUNERAL HOME 21. Signature of Funeral Service Licenses 0374 10565 Main Street Fairfax, VA 22030 23a. Part 1. Epte the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate the (Final disease or contition resulting in death)

Bladder Cancer Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) signed by the a 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has tirector, page 2 s autopsy perform 1 ☐Yes 2 No 1 ☐ Yes 2 X No after death.

Director: After this certific Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a filled 29a. Certifier l 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fil Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year)
Oct. 12, 2009 29b. Signature and title of certifier 29c. License number ٩ 0102201805 12 CCF 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NNMC 8901 Wisconsin Avenue Bethesda, Maryland 20889 Daniel Kim 62. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 0 2009 Registrar

	-	For State Registrar		of Marylan	id / Depa		of Hea	alth ar		ntal Hyg			35079
Physicia	an	1. Decedent's Name (First, Midd								Date of Dea Month	Day	Year	3. Time of Death
/Medic	al	Louis J. Crac 4a. Facility Name (If not institution		imbar)		4h City T	own, or Lo	eation of F		ctober	17, 2	2009 nty of Death	8:44pm [™]
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Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)		1 Year If	Under 24	Hrs. 8.	Date of Birth (Month, Day		9. Birth	place (State or Foreign ntry)
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within than than	Completed	Elementary/Secondary (0-12)		(1-4or 5+) 2		out Ed					News	paper	
other other vent,	Be C	17. Father's Name (First, Middle						. Mother's	s Name <i>(F</i>	irst, Middle,	Maiden Surr	* *	
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h and h and ris mi		19a. Informant's Name/Relation										wn, State, Zi	
permit. Pages 1 and 2 should be filed within 72 hours after death with the loadstream of Health and Mental Hygiene. Inportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examination at the retified at once.		Thomas Craca 20a. Method of Disposition	(Son)	20b. I	24316 Place of Disponentery, cre			Dri	ve, L			20872 on - City or T	
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aw ren as bec 2 shor	plete									24a. Was		4b. Were au	topsy findings available
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ter de irecto n by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 28e. Plac	ce of Injury - At h	ome, farm, st	reet, factory,	office		28f	. Location (8 City or Tov	Street and No n, State)	umber or Ru	ral Route Number,
purs at eral D filled i		29a. Certifier 1 🔀 Certify	ing Physician: To th	no bost of my kn	owledge dea	th occurred	at the time	data and	t place, an	d due to the	cause(s) and	d manner as	etated
To the hospital of Attending Prysician: The law requires that the beart certifical within 24 hours after death. Within 24 hours after death. Completely filled in by the funeral director, page 2 should be detached for use as the	Medical		I Examiner: On the										
vithir To th comp	Me	29b. Signature and title of certif	er		11	290	. License n	_	. 1		29d. Date si	gned (Month	n, Day, Year)
6		> Should	any	11	MD)		DS	139	1)		Octobe	r 19,	2009
		30. Name and address of perso	1	_			riol-	A = = =	#7.13	Co4	thorch	uiro '	MD 20877
Sta	te.	Suhair H. Abul 31. Date filed (Month, Day, Yea	r) 3 / 2.	Registrar's Sign	ature		TICK	Ave.	#4L3	, Gal	LHEESE	urg,	ED 20011
Regist		OCT 20	2009 Den	due p	1. Spa	Mad.							

Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		,	1 - State of Mary Registrar		artment of F rtificate of I			giene 200	9 35080
П	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day Ye	3. Time of Death
-	/Medic	cal	Eugene Eumnio Cervi 4a. Facility Name (If not institution, give street and number)		4b City Town or	Location of Deatl	10	4c. County of D	
أسم	Examin	ier	WMHS-Braddock Campus		^	mberla		Alleg	
	Funeral		187.	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		h ا و	Birthplace (State or Foreign
	Director		176-32-1019	71 Yrs.	Line Luye	1100.0	April .	13,1938	Pennsylvania
	/land			c. City, Town or Lo	cation				10d. Inside City Limits
	a-f sh	ctor	MD Garrett	McHenry					1 □ Yes 2 🙀 No
	or 28	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
	s 23a	Funeral	87 Wildwood Estates 11 Marital Status 12. Was Decedent Ever	in 110 100	21541	ii- O-i-i-2 /C	and Van and I	USA	
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Eventiral must be nothed at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ ★ Yes 2 □ No If Yes, Give Year or Dates;		Was Decedent of H fYes, specify Cuba 1 □Yes 2 ☑ No	Specify:	pecify Yes or No- o Rican, etc.)	Black, W	merican Indian, hite, etc. White
21215-0036	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup	ation	kina	16b. Kind of Busine	
2	ithin 7	mple	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done o	i)	ving	m	
, Q	filed w Hygie ther ti	ပိ	17. Father's Name (First, Middle, Last)	Truc	k Driver	18 Mother's Nan	ne (First Middle	Trucki Maiden Surname)	ng
auc	d be f ental ked of	To Be	Robert Cervi				Mauntino	,	
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street	and Number or Ru	ral Route Numbe	r, City or Town, Stat	e, Zip Code)
Σ,	and 2 ealth n 27 I		LeeAnn Diehl/Daughter		Box 481,				
Baltimore, Maryland	ges 1 nt of H if itel or oth		20a. Method of Disposition 2 1 □ Burial 2 🕱 Cremation 3 □ Removal from State	Ob. Place of Dispo cemetery, cren	sition (Name of natory or other plac	e)	Date	20c. Location - City	or Town, State
≣	nit. Pa artmer ortant Injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee		ide Crema			009 Davids neral Hom	sville, PA
Ba Ba	Departing any any any any		De Jun Journal		O. Box 2				
П			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ent	er the mode of dyin	ig, such as cardiad	or respiratory are	rest,	Approximate Interval Between Onset and Death
1	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)		ELL CA	LUN	16		UNKNOWN
1	Examiner		Due to (or as a con	nsequence of):					
	7 4	ner	Sequentially list conditions, if an Leadin, to immediate Due to (or as a condition of the	nsequence of):					
	ecuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.						
60,	ificate be executed physician and is the burial-transit	E E	resulting in death) Last Due to (or as a con	nsequence of):					
68760,	ficate physics the l	edical	d						
Box (leath certifi attending for use as	M/u	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pr		le			23d. Date of	delivery
O. B	e death	Physician/M	in the past 12 months? 1 Yes 2 No 4 Pregnant at time		Ectopic pregnancy Other (specify)	y ——————		Month	Day Year
<u>Ч</u>	nat the d by t letach	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but no	at requiting in the un	adortising passon site	on in Dort I	23a Did to	bacca use contribut	e to the cause of death?
Vital Records,	The law requires that the death cert ate has been signed by the attending age 2 should be detached for use a	d by	Part II. Other significant containons contributing to death but no	resulting in the ur	idenying cause give	en in Faitt.			Probably 4 Unknown
S	w requir	Completed					24a. Was a		autopsy findings available
Re	Physician: The law this certificate has t ral director, page 2 s	шо					autop: perfor	sy prior med? death	to completion of cause of
ta	stan:	Be C	25. Was case referred to medical examiner?			26. Place of Dea	1 ∐Yes th <i>(Check only or</i>	1 -	/es 2□No
<u>></u>	hysic this co	၉	1 Yes 2 No Hospital: Nopatient	2 ER/Outpatien		4 LI Nursing H	ome 5 Resid	ence 6 Other (S	Specify)
Division of	Jing F	ion:	27. Manner of Death Solution 28a. Date of Injury (Month, Day, Yes	ar) 28b. Time of Injury	28c. Injun Work		28d. Describe h	ow injury occurred	
l Sic	Atten death cctor: by the	fical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury -	At home, farm, stre		Yes 2 □No	28f. Location (S	treet and Number or	Rural Route Number.
á	s after	Certification:	4 ☐ Homicide determined building, etc. (S	pecify)		,	City or Tow		,
	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director, p.	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	y knowledge, death amination and/or in	n occurred at the tir vestigation, in my o	me, date and place pinion, death occu	, and due to the or rred at the time, o	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To th withir comp	Me	29b. Signature and title of certifier		29c. License		I .	29d. Date signed (Me	
		10	Willian Farm M	D	DC	00254	40G 1	October	19,2009
	+	101	30. Name and address of person who completed cause of death		Print)	0	,		19,2009 myland 21502
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's S	o Setoc Signature	Drive		in bette	and, Ma	ryland 21502
	Registr:		OCT 23 2009	. 1 1	Costa				

Registrar

State of Maryland / Department of Health and Mental Hygiene 2 35081 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10 Month Physician/ Day 13 2009 ROSALEE COLLINS 5:27 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY TAKOMA PARK WASHINGTON ADVENTIST HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 09 15 1935 Social Security Number 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Min. 1 🗆 M 2 🕱 F Hours DC Director 579 46 2846 74 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo **ADELPHI** MD PRINCE GEORGES 1^X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20783 1801 METZEROOT ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc 1 Never Married 2 Married þ Yes 2 🔀 No ltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify: If Yes, Give 3 - Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PARALEGAL FEDERAL GOVERNMENT 12th YEARS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ CLARA TILMAN EDWARD TOLSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 6611 KARLSON COURT HYATTSVILLE, MARYLAND 20783 CARZENA C. BUTLER/ COUSIN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 8 Removal from State MARYLAND NATIONAL 10-19-2009 LAUREL, MARYLAND Deniation 5 Other (Specify) 22. Name and Address of Facility of Funeral Signat 3005 12th STREET N.E. WASHINGTON, DC 20017 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final enses tile Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Ste Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 Yes 2 2 g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣ ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 XYes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certitying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D JAMES K. 7600 CARROLL AVENUE TAKOMA PARK, MD 20912

DHMH 17 Rev 7/2009

State Registrar 32. Registar's Si

State of Maryland / Department of Health and Mental Hygiene 2009 35082 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OCTOBER 2009 3:55A M CAMPBELL HELEN L. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, AUG • 28 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 M 2 X F VIRGINIA 1929 Director 80 579-32-4849 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, its modical Example and until the modical Example. 14 Yes 2 No WASHINGTON Director DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or? 20011 USA 5227 5th STREET N.W. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 🛛 No Specify. \$ Specify: 3 ☐ Widowed 4 🙀 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT DATA ENTRY 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BESSIE TIMMONS CHARLES SMITH ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1042 5th STREET GLENBURNIE, MARYLAND 21060 JEFFEREY A. CAMPBELL/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1 Department of h 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RESURRECTION CEMETERY 10-22-2009 CLINTON, MARYLAND Donation 5 ☐Other (Specify) 22. Name and Address of Facility 21. Signature Funeral Ser ce Licensee J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC LUNG CANCER /Medical Due to (or as a consequence of) Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): spital or Attending Physician: The law requires that the death certificate be executed tolous after death.

neral Director: After this certificate has been signed by the attending physician and iffiled in by the funeral director, page 2 should be detached for use as the burial-transit ACUTE RENAL FAILURE Due to (or as a consequence of): P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4√☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 🖾 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မှ 1 D Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jayanti D52586

State Registrar

DHMH 17 Rev 1/2001

1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's signatur

JAYANTI PATEL M.D.

31. Date filed (Month, Day, Year) 001 2 0 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 19, 2009 Preble Earle Donoho October 5:00 a M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Days 1**X** M 2 □ F Maryland 578-40-8109 79 Jan. 18, 1930 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a, State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examination at the notified at 1 ☐Yes 2 X No Director Silver Spring Maryland Montgomery 10g, Citizen of What Country? 10f, Zip Code 10e. Street and Number 20902 USA 11600 Orebaugh Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1★Nes 2□No If Yes, Give Year or Dates: 1951-59 14. Race - American Indian, 11. Marital Status Black White, etc. within 72 hours after 1 Never Married 200 Married Maryland 21215-0036 1 □Yes 21⁄2 No Specify Specify: ≥ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done curing most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filled win Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic more than the content that the content Newspaper 12 Typesetter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olivia Cook Christopher L. Donoho ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11600 Orebaugh Avenue, Silver Spring, MD 20902 Winifred B. Donoho/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory cr other place)
Arlington National
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition Oct. 22, 4 ☐ Donation 5 ☐ Other (Specify) 2009 Arlington, Virginia 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a Non-Small Cell Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and burial-trar Due to (or as a consequence of) attending physician Box 68760 Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Year Month Day ō 5 Other (specify) ☐Yes 2☐No P.0. the detached 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XX nknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 21 No has 1 ☐ Yes 2 ☐ No certificate Vital 1 Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 **N**O 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes of Certification: To 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Division Injury 1x Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 祝文 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the 9 October 19, 2009 D62571 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Sarah Bromeland, MD 1500 Forest Glen Road, Silver Spring, MD 20910

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) OCT 20 2009

			For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of ertificate of		Mental H	ygiene Reg. No. 20	09	3508
			1. Decedent's Name (First, Middle	, Last)				2. Date of D Month		V	3. Time of Death
н	Physici /Medi		Bonita Dem	n				10	02 20	Year	1120 AM
7	Exami		4a. Facility Name (If not institution	, give street and numbe	r)	4b. City, Town,	, or Location of Dea	ath	4c. County	of Death	
-			Holy Cross Hos	oital			Spring		Monts	gomer	У
	Funeral		5. Social Security Number	6. Sex 7. A 1 □ M 2 K F	age (In yrs. last birthday	Months Day		8. Date of B (Month, E	irth 7	 Birthpla Countr 	ice (State or Foreign
	Director		579-58-0553	1 U 241 F	65 Yrs.			Sept.	2, 1944	Washi	ngton, DC
	and w		Usual Residence of Decedent 10a, State 10b, County	- Hotel Hole Comment	10c, City, Town or L	ocation				100	d. Inside City Limits
	laryla i sho	ō			,,						1 □Yes 2X No
	28a-	rect	Maryland Montg	omery	Wheaton	10f. Zip Code			10g. Citizen of W	hat Countr	v?
	with Ra or	Ö									
	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Expresses.	Funeral Director	2403 Eugene Sti	12. Was Deceden	t Ever in U.S. 13		20902 f Hispanic Origin?	Specify Yes or N	United	- America	
10	fter d riter	F	1 ☑ Never Married 2 ☐ Marr	Armed Forces	?]No		f Hispanic Origin? (uban, Mexican, Pue	rto Rican, etc.)	Black	k, White, et	
036	urs ar	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates		1 □ Yes 2X N	o Specify:		Specify:	Whi	te.
21215-0036	2 hor	Completed by	15. Decedent	's Education	16a. Dec	edent's Usual Occ	upation		16b. Kind of Bu	siness/Indu	stry
21	hin 7 e. an "r	Jple	(Specify only highes Elementary/Secondary (0-12)	College (1-4or	5+)		ne during most of w red)	orking			
	d wit	lo G	12			Assistan	.t		Accour	nting	
nd	tal Hy	Be (17. Father's Name (First, Middle,						e, Maiden Surname	e)	
Va	Ment Ment arkec aric e	2	Charles Edward	Dern			Agnes	Frances	Martin		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Medical Examiner must be nutited at		19a. Informant's Name/Relations	nip (Type. Print)	19b. Mai	ing Address (Stre	et and Number or I	Rural Route Num	ber, City or Town, S	State, Zip (Code)
	and and n 27		Judith R. Harri	s/Sister				#913, N	W; Washi	ngton	, DC 2000
ore	of H		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation	2 Permoval from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other p	lace)	Date	20c. Location - (City or Tow	n, State
Ě	Pag ment ant: I		4 □ Donation 5 □ Other (S)		Ft. Lince	oln Crema	atory 10	/20/09	Brentwoo	d, Ma	ryland
Baltimore,	permit. Pages 1 and 2 s Department of Health a Important: If Item 27 is any Injury or other trau		21. Signature of Funeral Service	icensee	2	2. Name and Add	ress of Facility S	imple Tr	ibute		
_	g 5 5 6 9		MAG		1	040 Rock	ville Pil	ke; Rock	ville, M	2085	52
			23a. Part 1. Enter the disease, or shock, or/neart failure/ List	complications that cause	ed the death. Do not er line.	nter the mode of d	ying, such as cardi	ac or respiratory	arrest,		Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition	. Acu	TE CT	ROKE				'	Onset and Death
	/Medical		resulting in death)		s a consequence of):						
	Examiner		Sequentially list conditions	b. INTRY	ACEREBY	2AL F	LEMMO:	RHAC	E		om=
	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence of):					0	711
)	ecute and trans	am	Cause (Disease or injury that initiated events resulting in death) Last		RTENSIU	E EM	ERGEN	1C4	/ / W	10,1	1
30,	icate be executed physician and the burial-transit	E E	resulting in death) Last	Due to (or a	s a consequence of):			1 10	M	1 1	2/09
8760,	sate by sike the p	dical		d				X IV		0//	11/
9	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Mec	IF FEMALE:				71	1		-/-	
Вох	ath c	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregna	ncy (23d. Date Mor	of deliver	y Day Year
0	the a	sic	1 □ Yes 2 ♥ No 9 □ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of death 5	Other (specify)	100		l wo		, ay
P.0.	ires that the de signed by the a I be detached I	F.	Part II. Other significant condition	ne contributing to death	but not regulting in the	indorlying cause o	rivon in Port I	23e Did	tobacco use contri	ibute to the	cause of death?
ďs,	signe signe	ğ	art in other organical condition	no contributing to docum	bat not rocalling in the	anderlying oddae g	given in a dici.			3∏ Proba	
Ö	w requir s been s should I	Completed						· '			
3ec	e law has b	du					· -		san 24b. W	vere autops rior to com	sy findings available pletion of cause of
E F	cate pag	ပ္ပြဲ						pen 1 □ Yes	formed? d	eath? □Yes 2	. I⊇No
/ita	sician: The l certificate ha	Be	25. Was case referred to medical examiner?	Har Nati		1-		eath (Check only	one)		
Division of Vital Records,	shysi this o	ျ	1 Ves 2 No	Hospital: 1 Impai		III 3 LI DOA			sidence 6 Othe		
ň	ing I	Certification: To	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of In (Month, D	(ay, Year) Injury	W	jury at ork?	28d. Describe	how injury occurre	ed	
Sic	ttend death tor: the	cat	2 Accident investig 3 ☐ Suicide 6 ☐ Could r	ot bo			□Yes 2 No				18 HEAL
N N	or A after a Direction by	ıt.	4 ☐ Homicide determi	building, e	njury - At home, farm, st etc. <i>(Specify)</i>			City or To	(Street and Numbe own, State)		
	pital ours a eral I		29a. Certifier 1 Certifyin	g Physician: To the bes	t of my knowledge dea	BATH the accounted at the	ROOM time data and ala	2403 €	UGENE ST	15.5	100 CM.
	Hos 24 hc Fun	edical	(Check only one)	Examiner: On the basis and manners	of examination and/or i	nvestigation, in my	y opinion, death oc	ce, and due to the curred at the time	e cause(s) and ma e, date and place, a	nner as sta nd due to t	he cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Mec	29b. Signature and title certifier	and manner s	nateu.	29c. Lice	nse number	· I	29d. Date signed	(Month. D	av. Year)
	F 3 F 8		Ala	200100 A1	. M /	7	m) 1.	29	10 07	^ -	- 0
	1		20 Name and address of the	Jursen	4) 14	Dint)	UU6 7.	411	10,05	40	04
-			30. Name and address of person	•	death (Item 23a) (Type		500 FA	DECT 1	LEN RD	00	EUZ am
	Sta	te	31. Date filed (Month, Day, Year)		trar's Signature	1-1-1	300 (0	1-K21 6	TEN ICD	2100	· 150 Ma
	318		net on a	000 /	4 4.	11 1					

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State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

Physici		1 - State Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
/Medic		Lorraine E. Deeney		October	18, 2009	4:42 p _N
Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		3142 Gracefield Road, MG105	Silver Spring		P.G.	
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday, 89 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Sept. 3,	9. Birthp	place (State or Foreignty) Jersey
W #		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Letter (County)	ocation			0d. Inside City Limit
a-f sh	ctor	Maryland P.G. Silve	er Spring			1 □Yes 2 N
or 28	Jire	10e. Street and Number	10f. Zip Code	100	. Citizen of What Cour	itry?
23a	ra	3142 Gracefield Road, MG105	20904		USA	
ntal Hygiene. ad other than "natural", or items 23a or 28a-f show event, The Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Si if Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 No Specify:	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
natur	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation	dina 16	bb. Kind of Business/In	dustry
han "	ם	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	ang		
Hygie ther t		17. Father's Name (First, Middle, Last)	reacher 18 Mothor's Nam	e (First, Middle, Ma	Education	
ental l	Be	Peter Delafrange		1 Corson	iden Surname)	
and Mental is marked or raumatic eve	၉	<u> </u>	ing Address (Street and Number or Ru		City or Town, State, Zic	Code)
altha 27 is rtrau		1 1 1	105 Arbie Road, Si			
Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev once.		I Dunai Zal Ciemation 3 Li nemoval nom State I	matory or other place) Oc	t. 19	c. Location - City or To	
Departn Importa any inju once.			2. Name and Address of Facility Francis J. Collin 500 University Bl			
de physician and as the burial-transit	ledical Examiner	23a. Part 1. Exter the disease, or complications that caused the leath. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Coronary Artery Dispute to (or as a consequence of): b. Recent Myocardial Due to (or as a consequence of): Chronic Obstructive Curonic Obstructive Chronic Obs	isease Infarction (3/200	9)		Approximate Interval Between Onset and Death
O, 68	ian/Mec	1 Des 2 No. 4 Pregnant at time of death 5	□ Ectopic pregnancy		23d. Date of delive	ery Day Year
by the attendin ached for use	hysic	9 Unknown				Day teal
on signed by the attenuld be detached for us	ed by Physician/IV				cco use contribute to the	ne cause of death?
cate has been signed by the page 2 should be detached	Completed by	9□Unknown Part II. Other significant conditions contributing to death but not resulting in the u Crohn's Disease, Atrial Fibrillation	underlying cause given in Part I. on, Osteoporosis	24a. Was an autopsy performe	2 No 3 Prob	ne cause of death? pably 4 Unknown psy findings availat mpletion of cause c
certificate has been signed by the rector, page 2 should be detached	Be Completed by	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the uncertainty of the conditions contributing to death but not resulting in the uncertainty of the conditions of the	on, Osteoporosis 26. Place of Dear	24a. Was an autopsy performe 1 □ Yes 2 ₹	2 No 3 Prot	ne cause of death? pably 4 Unknov psy findings availat mpletion of cause c 2 No
is certificate has been signed by the director, page 2 should be detached	To Be Completed by	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the uncompared to the conditions contributing to death but not resulting in the uncompared to the conditions of the co	anderlying cause given in Part I. on, Osteoporosis 26. Place of Deal ont 3 DOA Other: 4 Nursing Ho	24a. Was an autopsy performe 1 □ Yes 2 ₹	2 No 3 Prot 24b. Were auto prior to co death? No 1 Yes De 6 Other (Specific	ne cause of death? pably 4 Unknov psy findings availat mpletion of cause c 2 No
u beaur. Irector: After this certificate has been signed by the n by the funeral director, page 2 should be detached	To Be Completed by	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the uncertainty of the conditions contributing to death but not resulting in the uncertainty of the conditions of the	26. Place of Dear of Mark 1. 26. Place of Dear of 28c. Injury at Work? M 1 Yes 2 No	24a. Was an autopsy performe 1 Pes 24th (Check only one) 28d. Describe how	2 No 3 Prot 24b. Were auto prior to co death? 1 Yes De 6 Other (Specifi injury occurred	ne cause of death? pably 4 Unknown psy findings availat mpletion of cause of 2 No
reactor: After this certificate has been signed by the frector: After this certificate has been signed by the n by the funeral director, page 2 should be detached	Certification: To Be Completed by	Part II. Other significant conditions contributing to death but not resulting in the carbon's Disease, Atrial Fibrillation 25. Was case referred to medical examiner? Yes 2 No	26. Place of Dearent 3 DOA Other: 4 Nursing Hoff 28c. Injury at Work? M 1 Yes 2 No reet, factory, office	24a. Was an autopsy performe 1 Yes 24th (Check only one) 28d. Describe how 28f. Location (Stre City or Town,	2 No 3 Prot 24b. Were auto prior to co death? No 1 Yes De 6 Other (Specifinjury occurred et and Number or Rura State)	ne cause of death? pably 4 □ Unknow psy findings availat mpletion of cause of 2 □ No y) If Floute Number,
reactor: After this certificate has been signed by the frector: After this certificate has been signed by the n by the funeral director, page 2 should be detached	To Be Completed by	Part II. Other significant conditions contributing to death but not resulting in the carbon's Disease, Atrial Fibrillation 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide Homicide See Place of Injury At home, farm, stouding, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	26. Place of Dearent 3 DOA Other: 4 Nursing Hoff 28c. Injury at Work? M 1 Yes 2 No reet, factory, office	24a. Was an autopsy performe 1 Yes 2* th (Check only one) 28d. Describe how 28f. Location (Stre City or Town, and due to the caurred at the time, dat	2 No 3 Prot 24b. Were auto prior to co death? 1 Yes De 6 Other (Specifinjury occurred set and Number or Rura State) se(s) and manner as se and place, and due to	ne cause of death? pably 4 Unknow psy findings availabmeletion of cause of 2 No 2 No y) If Route Number, attated. o the cause(s)
learh. for: After this certificate has been signed by the the funeral director, page 2 should be detached	Certification: To Be Completed by	Part II. Other significant conditions contributing to death but not resulting in the Crohn's Disease, Atrial Fibrillation 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 1 1 Inpatient 2 ER/Outpatie 28a. Date of Injury 28b. Time of Injury 28c. Place of Injury - At home, farm, stouched 28c.	26. Place of Dear 26. Place of Dear 27. Other: 4 Nursing Hold North No	24a. Was an autopsy performe 1 Tes 28th (Check only one) ome 5 Aresidence 28d. Describe how 28f. Location (Stre City or Town, and due to the caurred at the time, dat	2 No 3 Prot 24b. Were auto prior to co death? No 1 Yes De 6 Other (Specifinjury occurred et and Number or Rura State)	ne cause of death? pably 4 □ Unknow psy findings availab mpletion of cause o 2 □ No 2 □ No if Floute Number, tated. to the cause(s) Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10a £17 Per Hill 6899 11/26/2010 amend #10a £17 Per Hill 6899 11/26/2010 Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ ROSLYN DEVILLE OCTOBER 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CLINTON PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Funeral Days JAN 29 1 🗆 M 2 📉 Hours NEW YORK 1960 Director 49 052-54-6394 Usual Residence of Decedent ems 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No PRINCE GEORGE'S UPPER MARLBORO MD 10f. Zip Code 10e, Street and Number 10g, Citizen of What Country? Funeral items 23a P.O. Box 2175 20772 USA 7606 CHEW ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status er than "natural", or ite the Medical Examiner Armed Forces?
1 ☐ Yes 2 ☐XNo Black, White, etc. 1 Never Married 2 X Married δ Maryland 21215-0036 BLACK 1 Yes 2 XNo Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12TH NURSING ASSISTANT PRIVATE Be permit. Page 1 and 2 should be filed. Department of Health and Mental Humportant; If item 27 is meriany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANNA LOVELACE SHIRLEY BROWN 19a. Informant's Name/Relationship (Type, Print)
OSCAR LEWIS DEVILLE/HUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7606 CHEW ROAD UPPER MARLBORO, MARYLAND 20772 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) RESURRECTION CEMETERY 10-16-09 CLINTON, MARYLAND 22. Name and Address of Facility J. B. JENKINS FONERAL HOME 21. Signature of Funeral Service Licelpsee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 month 1 ☐ Yes 2 XNo 9 ☐ Unknown Month Day Year signed by the a d be detached f Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by decubites 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown SACTAL cate has been sig ; page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? OSTEUMYFULTIS 24a. Was an autopsy perform ESRD After this certificate 1 Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certified completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ြုင 1 🔀 npatient 2 🗌 ER/Outpatient 3 🔲 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Dyon Hill Rd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YSMAEL

31. Date filed (Month, Day, Year)

QUIADIT

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2009Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October 15, 2009 **Physician** V. Delanoche 3:53 PM Evangeline /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ft. Washington Prince George's Ft. Washington Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Jan. 19, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Year) 1951 Philippines Hours Months Days 1 □ M 2√2 F 58 579-80-4100 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mexical Examinar must be notified at 1 ☐ Yes 2 No Prince George's Director Ft. Washington Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1320 Christopher Lane 20744 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 全文的 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2X KMarried Baltimore, Maryland 21215-0036 1 □Yes 2√No Specify Filipino . þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Loan Document Specialist Banking vears 2 should be filed v and Mental Hygie Is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bienvido Valmonte Thomasa Manimtim 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau 1320 Christopher Lane Ft. Washington, Maryland Danilo Delanoche / Husband 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 10/20/2009 5 ☐ Other (Specify) Kalas Crematory 4 ☐ Donation Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature Juneral Service Licenses alan 6160 Oxon Hill Road Oxon Hill, Maryland 20745 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final METASTATIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner METASTAR if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, death certificate be Physician/Medical use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) ∐Yes 2**XX**No Ö 9 Unknown 9 Unknown signed by the ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, ģ i Yes 2 No 3 Probably 4 Whiknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ၉ 1 ☐ Yes 1 Izympatient 2 ER/Outpatient 3 DOA After this funeral dir 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural e Hospital or Attendii 24 hours after death. e Funeral Director: A letely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide e Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 26565 5056565 30. Name and a n who completed cause of death (Item 23a) (Type, Print) Samuel J. Kleiman MD 11711 Livingston Road Ft. Washington, MD 20744 31. Date filed (Month, Day, Yea OCT 2 0 2009 32. Registrar's Signature State Registrar

			_ State	State of Maryland		rtment of F		Mental Hy	giene Reg. No. 2009	35088
			Registrar 1. Decedent's Name (First, Middle, Last)		0071	inouto or E		2. Date of Dea		3. Time of Death
	Physicia		Charles Newton Darn	ell, Jr.					2009 2009	11:54 AM
	Medic Examin		4a. Facility Name (if not institution, give stree			4h City Town or	Location of Death		4c. County of Dea	
	Examili	ei	14705 Lancraft Cour			Germant		,	Montgom	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last i	birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h 9. Bit	thplace (State or Foreign
	Director		213 30 7042	^{2□F} 60	Yrs.	World S Days	Hours Will.	0ct. 30	Year 1948 Pan	ama
2	how	<u>-</u>	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loc	ation				10d. Inside City Limits
200	a-f s fied	ectc	MD Montgomery	German						1 ₺ Yes 2 □ No
Ā	or 28	Ē	10e. Street and Number	OCTINAT	icowii	10f. Zip Code		T	10g. Citizen of What C	
with	s 23a ust b	Funeral Director	8 O'Neill Drive, Apr	. 6		20874			U.	S.A.
heath	item:	臣		Was Decedent Ever in U.S. Armed Forces?			spanic Origin? (Sp n, Mexican, Puerto		14. Race - Ame	
36	", or	by	1 Never Married 2 Married	1 ☒ Yes 2 ☐ No					Black, Whit	
	atural sal Ex	Completed by	3 ☐ Widowed 4 🔀 Divorced 15. Decedent's Educa	Year or Dates. 1969-19			Specify: Pan	amanian		White
15.	in "ng Medic	햩	(Specify only highest grade of	ompleted)	(Give k	ent's Usual Occup ind of work done of NOT use retired)	ation luring most of wor	king	16b, Kind of Business	Industry
212 within	jiene.		Elementary/Seconday (0-12)	College (1-4 or 5+)	Cashi	,			Grocery St	ore
Maryland 21215-0036	d oth	Be	17. Father's Name (First, Middle, Last)						Maiden Surname)	
<u>a</u>	Menta arked aric e	잍	Charles Newton Darne	211, Sr.			Angelica	Nellie	Fernandez	
Aar	is m		19a. Informant's Name/Relationship (Type, I	· ·					; City or Town, State, Zi	
e, ►	fleath and Merital Hygiene items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Jerry W. Darnell/Bro				l Place,		le, MD 2073	
imor Page 1			1 ☐ Burial 2 🖾 Cremation 3 ☐ Ren	noval from State ceme	etery, crem	ition (Name of atory or other place		Date	20c. Location - City or	
Baltimore,	Department Important: I any injury o	1	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of funeral Service Licensee	Metro		n Cremator Name and Addres		22/2009[Alexandria	, Virginia imore Ave.,
Balt	lmpc any i		H Constance	Gaseh				ome, P.A		1e, MD 20781
			23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one ca		o not enter	the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	ysician/	17	Immediate Cause (Final disease or condition	Coronary Arte	ery D	isease				Onset and Death
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		ē	Sequentially list conditions, if any, leading to immediate	Hypertension Due to (or as a consequence)	ce off:					
pet	nsit	Examiner	Cause. Enter Underlying Cause (Disease or iinjury	Hypercholeste		nia				
execu	in and ial-tra	Ex	that initiated events c resulting in death) Last	Due to (or as a consequence						
Box 68760 death certificate be executed	physician and the burial-transit	dical	d							
6876 ertificat	ng ph as th	Mec	IF FEMALE:							
X 6	been signed by the attending p should be detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnancy 1 Live Birth 2 Fetal de	eath 3 🔲	Ectopic pregnand	у		23d. Date of de	
		ysic	1 Ves 2 No	4 ☐ Pregnant at time of deat 9 ☐ Unknown	th 5 ∐	Other (specify)			Month	Day Year
cords, P.O. law requires that the	d by Jetacl	Ph	Part II. Other significant conditions contrib	outing to death but not resulting	ng in the un	derlying cause giv	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
S, P.	signe d be o	d by						1 🗆 1	∕es 2 □ No 3 🖾 F	Probably 4 🗆 Unknown
Drd	been	Completed						24a. Was a	an 24b. Were au	itopsy findings available
Rec The law		ᄩ						autop perfor	sy prior to med? death?	completion of cause of
	certificate rector, pag	BeC	25. Was case referred to medical			26. Pl	ace of Death (Chec	1 Yes	2 No 1 ⊔ Ye	s 2 No
Vita ysicia	is cer direct	To B	examiner? 1 ☐ Yes 2 ☒ No	ital: 1 ☐ Inpatient 2 ☐ ER	/Outpatient	Othe			ence 6 😾 Other (Spec	Friends residence
o ag	ter th		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	b. Time of injury	28c. Injury work	at		ow injury occurred	
On	eath. or: Ai the fu	ijica	2 Accident Investigation 3 Suicide 6 Could not be				Yes 2 □ No			
Division of Vital Records, tal or Attending Physician: The law requires	within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	4 Homicide determined	8e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office		28f. Location (S City or Town	treet and Number or Ru n, State)	ral Route Number,
Spital	neral neral	ical	29a. Certifier 1 🔀 Certifying Physician	n: To the best of my knowledg	ge, death o	ccured at the time,	date and place, a	nd due to the cau	se(s) and manner as st	ated.
he Ho	n 24 l	Medical	(Check 2 Medical Examîner:	On the basis of examination an actioner: To the best of my kn	d/or investi	gation, in my opinic	n, death occurred a	at the time, date ar	nd place, and due to the	cause(s) and manner stated.
Tot	with Com		29b. Signature and title of certifier	A X		29c. License	number		29d. Date signed (Mont	
	6		- Lelip			D00661	13		10/19/200	9
1	Va		30. Name and address of person who comp Deborah B. Horwitz,				e 401. F	Sethesda	, MD 20817	
	Stat		31. Date filed (1 on th. Day, 2009 A	32. Registrar's Signatus)			,	
	Registra	ar	001 & U 2000 /A	T 7						

State of Maryland / Department of Health and Mental Hygiene 35089 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Oct. 15, 2009 Year **Physician** 4:10p M Evans J. Doris /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Casey House If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day) **Funeral** Days Hours Min. 1 M 2 X F 12/09/1921 187-16-2009 87 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show Gaithersburg 1 ☐ Yes 2 ☐ No Director MD Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 20882 8129 Seneca View Drive death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White δ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic event, Italiano. Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sarah M. Haslam Frank Accardi 19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Samantha Evans/Granddaughter 10759 Cordage Walk Columbia, Md. 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State St.Clair, PA. Odd Fellows Cem. 10/20/2009 5 ☐ Other (Specify) 4 Donation PHYTCIPADESRIVALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** End stage renal disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Renal lymphoma Sequentially list conditions Physician/Medical Examiner Due to for as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, The law requires that the death certificate attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. 1 ☐ Yes 2 No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Nown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page certificate 1 ☐ Yes 1 ☐ Yes 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: $_{4\square \text{ Nursing Home}}$ 5 \square Residence 6 buildrel Other (Specify) hospice1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 XNatural investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) Oct. 16, 2009 29b. Signature and title of certifier Koucetchou, 263742 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muntcaster Mill Road Rockville, Md Jocelyne Koudtchou M.D. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State OCT 20 2009 Registrar

Physician Medical Examiner Grace Josephine Eaton Grace Josephine Eaton Grace Josephine Eaton Grace Josephine Eaton Month October 18, 2009 6: Maryland Cecil Functal Director Functal Dir	090
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P. V. Nage N. M. D0065733 10/19/59	Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NARATANA RA V. PULA, 126 A E. HTGH STREET. ELKTON, MD - 21921	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar OCT 6 0 2009	

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	/Medic Examin	al		Harriet If not institution, give	Esteb street and number)		T	4b. City, Town, or	Location of Death	Octobe:		2009 County of Death	9:00 A M
	LAGITIII	CI			ed Living			Dayton			Hov	vard	
	Funeral Director		5. Social Security N 528-28-3	Number 6. S 3584 1		e (In yrs. last bin 85	thday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan 8,	1924	9. Birthp Coun Chin	lace (State or Foreign try) a
	and ow		Usual Residence of 10a. State	10b. County		10c. City, Town	n or Lo	cation				1	0d. Inside City Limits
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Physician
/Medica
Examine

Funeral Director 28a-f show ö filed within 72 hours after death

Injury or other traumatic event, the Mudical Examinar must be notified at Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Magnetic event e

Physician

/Medical

Examiner Box 68760. P.O. Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be executed funeral director, hours after death. neral Director: / filled in by the fi within 24 hours a

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCT 14, 2009 JOSEPH M. FORD 2:45 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Nursing & Rehab Center Rockville MONTGOMERY If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Month Day, May 14, 9. Birthplace (State or Foreign Social Security Number 6. Sex Days Hours Min. Mary land 1 □ M 2 □ F 93 218-01-8861 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No Director MD Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 617 N. Stonestreet Avenue 20850 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 ☐ No 1 Never Married 2 Married If Yes, Give Year or Dates: 41–46 1 ☐ Yes 2√☐ No Specify: Specify: Black 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 6th College (1-4or 5+) Cement Finisher Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Moses Ford Annie Williams ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Oglesby (Niece) 2124 Lorraine Ave, Gwen Oak, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Verterans Cem 10/21/09 Cheltonham, MD 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. Funeral Service License 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease or complications that caused the death on not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung Cancer Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes **X**□No 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? 1 ☐ Yes 2 🛣 No Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/16/09 H005128 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anushiravan Dadgar, 10110 Molecular Dr, Rockville, MD 20850 M.D. 31. Date filed (Month, Day, Year) . Registrar's Signature State OCT 20 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35093 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Vear **Physician** James Madison Flaharty, Sr. 01:20 PM October 2009 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 248 Firetower Road Port Deposit Cecil If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Days 1929 Port Deposit 1**X** M 2□ F Months 217-28-1453 Director 79 Nov. 29. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 Tyes 2 XNo Director Maryland Cecil Port Deposit 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 248 Firetower Road 21904 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married If Yes, Give Year or Dates: 1 ☐Yes 2 🙀 No Specify White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Cancer Research Biochemist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Alice Huss Harry Madison Flaharty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 248 Firetower Road, Port Deposit, Maryland 21904 Mavis L. Flaharty / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bible Fellowship
Baptist Cemetery 20c. Location - City or Town, State 20a. Method of Disposition October 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 24, 2009 Rising Sun, Maryland 22. Name and Address of Facility Crouch Funeral Home 21. Signature of Funeral Service Licensee Mobile 127 South Main Street, North East, Maryland 21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** unknown CARCINOMA COLON disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CARDID HYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and -tran Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) been signed by the should be detached ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည After thi funeral of 27. Manner of Death 1 A Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

> BLKTON MD-21921 mut 126 A E. HIGH PULA NARAYANA 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 2 0 2009

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Registrar

29a. Certifier

(Check only one)

29b, Signature and title of certifier

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DOO 65733

29d. Date signed (Month, Day, Year)

			1 - State of Ma	ryland / l	Depa <i>Cer</i> i	rtment of He tificate of D	ealth and M Death	lental Hyg ¤	jiene _{eg. No.} 2	009	35094
â	Dhi.i		1. Decedent's Name (First, Middle, Last)					Date of Dea Month		Year	3. Time of Death
	Physicia /Medic		Lucy Vertis Friend					October	20, 2	2009	10:08 A ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or				nty of Death	
	Functor		411 0 Street 5. Social Security Number 6. Sex 7. Age	(In yrs. last bi	rthday)	Mtn. Lal	If Under 24 Hrs.	8. Date of Birth		rett 9. Bjrth	place (State or Foreign
	Funeral Director		220-24-7961 1 M 2X F 9:	3	Yrs.	Months Days	Hours Min.	July 25	1916	1	yland
	-		Usual Residence of Decedent								
	arylan show d at	_	10a. State 10b. County	10c. City, Tow	n or Loc	ation					10d. Inside City Limits 1 1 Yes 2 No
	ne Ma 8a-f s atifie	Director	MD Garrett	Mtn.	Lak	e Park			10- Oili	- (\M/h = 1 Co :	
	with the	Ö	10e. Street and Number			10f. Zip Code			l0g. Citizen o		
	eath ns 23	eral	411 O Street 11. Marital Status 12. Was Decedent S	ver in U.S.	13. W	21550 /as Decedent of His	spanic Origin? (Sp	ecify Yes or No-		ed Sta	
2	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentel Hygiene. It health and Mentel Hygiene item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ X*N		If	Yes, specify Cubar	n, Mexican, Puerto	Rićan, etc.)		Black, White	, etc.
	al", o Exan	by	3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates:		1	□Yes 2MNo	Specify:		Spe		ite
2	72 hc natur lical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a	(Give k	ent's Usual Occupa	uring most of work	ing I	16b. Kind of	Business/II	ndustry
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7	lled w Hygie her ti	ပိ	12 17. Father's Name (First, Middle, Last)		Cle		18. Mother's Nam	e (First, Middle,		ry St	ore
ם ם	d be f	Be c	David E. Ream					M. John		,	
	should ad Me mark matic	၉	19a, Informant's Name/Relationship (Type, Print)	19	b. Mailing	Address (Street a				vn, State, Zi	ip Code)
2	nd 2 sulth ar		Jacqueline Hinebaugh, Daugh	nter	411	O Street,	Mtn. La	ke Park	. MD 2	1550	
ָּבְּ	ss 1 and 2: of Health a item 27 is other trau		20a. Method of Disposition	20b. Place of	of Dispos	sition (Name of natory or other place		Date / 2009	20c. Locatio		own, State
=	Page Tent c Int: If		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)			emorial (10/24	1/2009	0akla	ınd, M	D
Dallillor	permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Licensee		22.	Name and Addres	s of Facility Burdock	Funera	1 Home	, P.A	٨
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do	not ente	er the mode of dying	g, such as cardiac	or respiratory an	rest,	, 2133	Approximate
*	Physician		shock, or heart failure. List only one cause on each lir Immediate Cause (Final disease or condition resulting in death)			euren					Interval Between Onset and Death
	/Medical Examiner		Due to (or as	a consequence	of):						
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events								
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0/00,	death certificate be executed e attending physician and ed for use as the bunal-transit	dical	d								
Ō	ertific ling p	Mec	IF FEMALE: 23c. If yes, outcome	of prognancy					1		
DOX	w requires that the death certific been signed by the attending f should be detached for use as	Physician/Me	in the past 12 months?	2 Fetal deat		Ectopic pregnancy Other (specify)				Date of deli Month	Day Year
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cords	quires n sign	ed by						1 D Y	es 2	o 3∐Pro	obably 4 □Unknown
ဝင္ပ	law re as bec 2 sho	Completed						24a. Was autop	an 24	tb. Were au	topsy findings available completion of cause of
r	The late has page	E O						perfo	rmed2 2 □ No	death?	2 □ No
VIE	sician: The law certificate has birector, page 2 s	Be (25. Was case referred to medical examiner?			Law Law	26. Place of Dear	th (Check only o	ne)		
20	hysio this or al dire	ြိ	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatie		•	3 DOA Othe	4 LI Nutsing H	ome 5 desid			pify)
	Jing F	ion:	27. Manner of Death 1 Accident investigation 28a. Date of Inju (Month, Da)	y Year)	Time of Injury	28c. Injury Work M 1 □	/at ⟨? Yes 2 □ No	28d. Describe h	low injury oc	curred	
VISION	death ctor: y the	licat	2 Accident	ury - At home, f	arm, stre	eet, factory, office		28f. Location (S	= Street and Nu	ımber or Ru	ral Route Number,
2	after after I Dire	Certification:	4 ☐ Homicide determined building, etc.	c. (Specify)				City or Tou	vn, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best on the basis of and marker sta	f examination a							
	omple	Mec	29b. Signature and title of certifier			29c. License	number		29d. Date sig	gned (Monti	n, Day, Year)
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			30. Name and address of person who completed cause of d	eath (Item 23a)	(Type, I	Print)				- 18	
		4		311 N F	ourt	h Street	0aklan	d, MD 2	1550		
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 For State Registra MFND#1600erFH, 10-20-09, BMW, MoCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month October 18, 2009 Physician 9:35 p M Elizabeth Mullen Mamie /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Holy Cross Hospital 8. Date of Birth (Month, Day, Aug. 4, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Months Hours ^{Year)} 1923 1 □ M 2 🖺 F Mississippi Aug. 426-36-5539 86 Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Michael Erminian in ast by muffiled at once. 1 □Yes 2 X No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20902 USA 9900 Georgia Avenue, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black White, etc. 1 ∐Yes 2 If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 € No Specify. Specify: White 2 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Interior Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Mamie Elizabeth Turner John Pitts Mullen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3 Bethesda Metro Center, #460, Bethesda, MD 20814 19a. Informant's Name/Relationship (Type. Print) Sigrid Haines/Personal Rep. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition Oct. 19 1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State Metropolitan Crematory 2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral 500 University Blvd. W., S 21. Signature of Funeral Service Licensee Home Inc Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final days Pneumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** days Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-transi Dementia and that initiated events resulting in death) Last Due to (or as a consequence of): physician pe Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant death 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Por Month Year 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown s been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 X No Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☐ No 2 ER/Outpatient 3 DOA 1 XInpatient this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No spital or Attendil ours after death. neral Director: A death. 2 Accident 6 Could not be 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled in Hospital 29a. Certifier XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month. Day. Year)

Box 68760.

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of Vital Records,

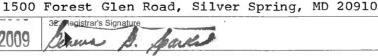
Division

State Registrar 31. Date filed (Month, Day, Year) 20 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Ira Rabin, MD



29c. License number

D61887

October 19, 2009

State of Maryland / Department of Health and Mental Hygien 2009 35096 Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 **Physician** Elaine Esmond Giles 7:35 a October 16, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 ☐ XF Trinidad, WestIndies Director 321-52-9290 89 May 16, 1920 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 X No 3a or 28a-f sh Director Maryland Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10407 Grandin Road 20902 Trinidad, West Indies nem z7 is marked other than "natural", or items 23a other traumatic event, the Mudical Examination of the control of the contr Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo **Black** Specify: þ 3 Widowed 4 X Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nurse's Aide 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Thompson Osmande Jackson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert L. Giles/Son 25 Yeatman Court, Silver Spring, MD 20902 20c. Location - City or Town, State San Fernando, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition October 24 1 XBurial 2 ☐ Cremation 3X Removal from State Roodal Cemetery Trinidad, West Indies 4 Donation 5 Dother (Specify) 2009 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Williamson Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finai **Physician** Subdural Hematoma disease or conditio /Medical resulting in death) Due to (or as a consequence of): Examiner le, Xm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed Sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) 0 physician sthe burial Box 68760. 0 Physician/Medical signed by the attending place as the detached for use as IF FEMALE: ves, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) Yes 2000No Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, و Atrial Fibrillation, Hypertension 3 Probably 4 Unknown 1 Tyes 2X No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? 1 □ Yes 2 □ No 2 🗆 No certificate 1 TYes Division of Vital e Hospital or Attending Physician: 1 24 hours after death.
Funeral Director: After this certifical director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) P. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 1 🗷 inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 □ Natural 8:00 am Fall 10/10/2009 1 ☐ Yes 2 X No 2x Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Bural Route Number, City or Town, State) 10407 Grandin Rd., 4 Homicide At Home Silver Spring, MD 20902 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D60826 October 16, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20901 Kshama Garg, MD

31. Date filed (Month, Day, Year)

OCT

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 35097 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1) PM NANA a.a 2+0 MOST stubor 2009 4b. City, Town, or Location of Death 4c. County of Death . Facility Name (If not institution, give street and number, The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign
Country) Social Security Number Months Days 3/27/1950 1 M 2X F Georgia 214-37-1836 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10b. Count 1 ☐ Yes 2 🙀 No Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 11805 Fernshire Road 20878 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11 Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Yes White 1 Yes 2 No If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Nat.Institute of Elementary/Secondary (0-12) College (1-4 or 5+ Standards&Technology Sales and Advertising 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Givi Gegetchkori Tsotso Vekua 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anzor Mikai/Husband 11805 Fernshire Road Gaithersburg, Md20878 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 10/27/2009 3 K.Removal from State 1 XBurial 2 Cremation Tbilisi, Georgia 4 Donayon 5 Other (Speq Saburpalo Cemetery of Funeral S PHILIP ACTOR ACTOR P.A. SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 - Fetal death Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year ☐ Pregnant at time of death☐ Unknown 5 Other (specify) 9 Unknown

permit. Pages 1 and 2 should be filet.
Department of Health and Mental Hygin Important: If item 27 is marked ---any injury or other Immore. **Physician** /Medical Examiner

attending physician and

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page 2 should been

has

certificate

Physician;

or Attending

To the I within To the

death.

24 hours after Hospital

To the Funeral Director: After this certifica completely filled in by the funeral director,

Physician/Medical

Completed by

Be

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Certification:

Medical

The law requires that the death certificate be executed

of Vital Records, P.O. Box 68760,

Division

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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"natural", or iten edical Examiner r

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner

21. Signal

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 DOA

23e. Did tobacco use contribute to the cause of death?

3 Probably 4 Unknown

2 🛮 No 1 Yes 24a. Was an autopsv performed

24b. Were autopsy findings available prior to completion of cause of death? 2 🗌 No 1 Yes

2 Z No 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify)

28d. Describe how injury occurred

600 North Wolfe St, Baltimore, MD, 21287

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and que to the cause(s) and manner account at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

5 Pending investigation

6 Could not be

determined

Injury at Work?

29c. License number

1 ☐ Yes 2 ☐ No

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who

1 Inpatient

(Month, Day Year)

28a. Date of Injury

We 31. Date filed (Month, Day, Year,

29b. Signature and title of certifier

25. Was case referred to medical

1 ☐ Yes 2 ☑ No

27. Manner of Death

1 ✓ Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

(check only one)

> 20 2009

M D 2. Registrar

2 ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

State Registrar

State of Maryland / Department of Health and Mental Hygiene 2000

	1	State of Maryland / Department of State of Maryland / Department / Dep	of Health and I of Death	Mental Hygi Re	iene 2009	35098
Physicia		1. Decedent's Name (First, Middle, Last) Jonah Otelsberg Goodwin		2. Date of Death Month October	Day 2009	3. Time of Death 6:00 PM
/Medica Examine		4a. Facility Name (If not institution, give street and number) 4b. City, Tow	vn, or Location of Death		4c. County of Deat	th
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y	Year If Under 24 Hrs. lays Hours Min.	8. Date of Birth (Month, Day, Aug. 6,	Year) 9. Birt Co	thplace (State or Foreign ountry) Warsaw oland
ind ZIZIS-UUSC be filed within 72 hours a tal Hygiene. d other than "natural", o event, tre Medical Extr.	To Be Completed by Funeral Director	11. Marital Status 1	Ode 1901 Couban, Mexican, Puert INO Specify: Occupation fone during most of wore religied) 18. Mother's Name Esthe Chartest and Number or Rules (Chartest) Avenue, No of relace) Coubant (No of relace) Oct	pecify Yes or No- o Rican, etc.) rking cian ne (First, Middle, M r Goldwag ural Route Number erth Last Date ober	Og. Citizen of What Co United Sta 14. Race - Ame Black, White Specify: WI 16b. Kind of Business/ Education faiden Surname) City or Town, State, A	ates erican Indian, e, etc. hite /Industry Zip Code) 21901 Town, State
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To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical Co	1	n my opinion, death occi	urred at the time, d	ate and place, and du 9d. Date signed (Mon	e to the cause(s)
6		30. Name and address of person who completed cause of death (Item 23a) (Type Print)	0065733		10/19/09	1921
Stat Registra		NARAYANA RA V. PULA, 176 A E. ITT 31. Date filed (Month, Day, Year) OCT 2 0 2009 32. Registrar's Signature A. January B. January	IGH ZINGT	, (MK)	00,110 2	1761

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Ņ	Physicia	n/	1. Decedent's Name (First, Middle, Las	i) 11ian Cecelia	a Green	n			2. Date of Dea October 1	th	Year	3. Time of Death 3:15P M
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	s 23a c	Funeral Director	3800 Lottsford Vista	n Road			20721			US		
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time ZI is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 [X] Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	er in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rac Blac 1 Yes 2 No Specify: Specify:						ce - Americ ack, White, o y: Whi	etc.
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Baltimore, Maryland 21215-0036	be filed lental H rked ot ic ever	면 의	17. Father's Name (First, Middle, Last) Roger Franklin Myers	5				18. Mother's Nam Hannah Bl	e (First, Middle, I anche Wh		ne)	
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Vita	hysicia nis certi I directo	To Be	examiner? 1 🗌 Yes 2 🗡 No	Hospital: 1	2 🗆 ER/0	Outpatien	Othe	r: 4 Nursing Ho	ome 5 🗆 Resid	ence 6 🗆 Oth	ner (Specify)
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Divisio	3 Suicide 4 Homicide 3 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 5 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and No. City or Town, State)											Route Number,
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K	4		30. Name and address of person who willie Jarrell, CRNP	completed cause of deat	th (Item 23a)		rint)			/ 0 = /	<u></u>	
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Funeral Director		5. Social Security N 214-52-22	208	Sex 1□M 2∏x			last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D 04/02/	rth av. Ye <i>ar</i> 1947	9 7 M	Birthp Coun D	lace (State or Foreign try)	
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FF 8		30. Name and addr	ress of person 🛵	completed	cause of d	leath (Iten	n 23a) (Type,	Print)	164	number 128 973 Be	3 Hea	1+44	0/15/2	200	2	
ET 8		JUSUN SZ 31. Date filed (Mon.	th, Day, Year)	o A	+Lant	ar's Signa	ture	Ito sp	176.1	Be	rling	41)	2181			
Registra	ır	U	OCT 192	.009	Consu	~ /	D. 190	uks								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 09:42 ^MAM 19 2009 October Edith May Ralston Irwin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** E1kton Cecil Caraway Manor Assisted Living 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country Leeds
Sept. 19,1930 Maryland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Min. 1 □ M 2 🗓 F Yrs Director 79 219-28-2029 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland North East Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Completed by Funeral 21901 United States 766 Hances Point Road Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: White 3 Midowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith May Castelow James C. Bowlsbey, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 116 Phyllis Frive, Newark, Delaware 19711 Debra Anne Minor / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Rose Bank Cemetery 23, 2009 Rising Sun, Maryland 21. Signature of Funeral Service Livensee 22. Name and Address of Facility Crouch Funeral Home 14/1 South Main Street, North East, Maryland21901 127 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** MUS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 🗆 Ectopic pregnancy Month Year Day Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No P.0. 9 Unknown 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? 1 ☐ Yes 2 🗷 No certificate 1 ☐ Yes 2 No e Hospital or Attending Physician: 124 hours after death. e Funeral Director: After this certifica letely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day, Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide completely filled t X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

OCT 2 0 2009 32. Registrar's Signatur State Registrar

State of Maryland / Department of Health and Mental Hydienes and O

			For State Registrar	State of Mic	-	Certificate of			2009	35102					
	Physicia		1. Decedent's Name (First, Middle, La	-	t Jeffrey			2. Date of Death Month Octo	ber 14, 2009	3. Time of Death 4:05 M					
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town,	or Location of Death		4c. County of Death	lagany					
	Funeral			06 Seldom See 1 № 12 F 7. Age	e (In yrs. last birth	Months Days	r If Under 24 Hrs.	8. Date of Birth (Month, Day,	O Dieth	legany place (State or Foreign					
	Director		214-30-9650 Usual Residence of Decedent	IJAM 2LIF	78 Y	rs.		March	13, 1931	Maryland					
	// Aaryland f show	or	10a. State 10b. County Maryland A	llegany	10c. City, Town	or Location	Lonaconing	y .		0d. Inside City Limits 1 □Yes 2 No					
	or 28a-	Director	10e. Street and Number			10f. Zip Code			Og. Citizen of What Cou	•					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy highly or other traumatic event, the Medical Eventral must be notified at once.	Funeral	22110 S 11. Marital Status	eldom Seen Ros		13. Was Decedent of If Yes, specify Cu	21539 Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Ameri	USA 14. Race - American Indian,					
036		by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	Yes 2X No es, Give		Specify:	nican, etc.)	Black, White, Specify:	White					
15-0	in 72 hc n "natur	Completed by	15. Decedent's E (Specify only highest gi	ducation rade completed) College (1-4or 5		Decedent's Usual Occ (Give kind of work don life. DO NOT use retir	e durina most of work		16b. Kind of Business/In	dustry					
212	led with Hygiene her thai	Com	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Las	0	+)		Laborer	e (First, Middle, N		extile					
/lanc	should be filed within nd Mental Hygiene. marked other than Imatic event, Ille Ille	To Be	17. Fauter's tvarie (First, Milotic, Las	George Jeffr	ey		To: Modific o Hair	1eadie Green							
Maryland 21215-0036	id 2 sho lith and I 27 is ma trauma		19a. Informant's Name/Relationship Florence		19b.	,			, City or Town, State, Zi oning, Maryland						
altimore, 1	Pages 1 and 2 ment of Health ant: If item 27 ary or other tr		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 I 4 □ Donation 5 □ Other (Spec			Disposition (Name of a crematory or other parts) ostburg Memoria		20c. Location - City or Town, State Frostburg, Maryland							
Balt	permit. Departr Imports any Inje		Frostburg Memorial Park 2009 Frostburg Memorial Park 2009												
68760,	rificate be executed 'Medical Examiner as the burial-transit	Medical Examiner	23a. Part 1. Enter the disease, or cor shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequendary list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	the death. Do nie. consequence of a consequence of the con	n:	ech y	4 0	PASCINURA	Approximate Interval Between Onset and Death					
O. Box	ath cel	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death	3 ☐ Ectopic pregna 5 ☐ Other (specify)		23d. Date of deliv	very Day Year						
rds, P.	juires that the de n signed by the a ild be detached fi	by	Part II. Other significant conditions	contributing to death be	ut not resulting in	the underlying cause (given in Part I.		oacco use contribute to es 2 ☑No 3 ☐ Pro						
al Records,	: The law requir cate has been s , page 2 should I	Completed						24a. Was a autops perforr 1 🗆 Yes	y prior to content of the death?	opsy findings available ompletion of cause of 2 □ No					
Division of Vital	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To Be	25. Was case referred to nedical examiner?	28a. Date of Inju (Month, Da	iry 28b. T y, Year) Ir	ime of jury 28c. In	Other: 4 Nursing Figury at ork?	28d. Describe ho	ence 6 Dother (Spec ow injury occurred						
Δ	ospital or hours aftu uneral Dii ly filled in		29a. Certifier 1 Lertifying I	Physician: To the best	of my knowledge	, death occurred at the	time, date and place	e, and due to the d	ause(s) and manner as						
	To the He within 24 To the Fu complete	Medical	29b. Signature and title of sertification	and manner sta			nse number		9d. Date signed (Month						
	->=0		> ////	agan	env	2 L	1221	P) (Detober	15,2009					
_		5	30. Name and address of person wh	completed cause of d	leath (Item 23a) (Type, Print) Shoo Wa	IshDay	e, Cum	her bind i	no 21502					
Ì	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	ha that		, -	,						

			State of Maryland / Dep	delible ink. Ensure All artment of Health and M	ental Hvaid	re Legible.				
			For State Registrar Ce	rtificate of Death	Reg	2009 35103				
	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year 3. Time of Death				
No.	/Medic	al	Wilfred Charles JACKSON 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	October	21, 2009 7:50 a. ^M				
of.	Examin	er	1105 Salem Avenue	Hagerstown						
П	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	9. Birthplace (State or Foreign Country)				
	Director		216-22-9673 152 M 2 F 81 Yrs. Usual Residence of Decedent		Feb. 28,	1928 Maryland				
	ryland show	L	10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits				
	be filed within 72 hours after death with the Maryland stal Hygiene. d other than "natural", or items 23a or 28a-f show event, I'm Mcdical Enariener rust be notified at	Director	Maryland Washington Hagers 10e, Street and Number	stown 10f. Zip Code	100	1 ☑ Yes 2 ☐ No				
		Ē	1105 Salem Avenue	21740	100	USA				
	ems 2	Funeral		Was Decedent of Hispanic Origin? (Sper If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.				
36	s after	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1950-54	1 ☐Yes 2 X No Specify:		Specify: white				
21215-0036	2 hour	ted t	15 Decedent's Education 16a, Dece	dent's Usual Occupation	16	16b. Kind of Business/Industry				
121	within 7 ene. than "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of workin DO NOT use retired)						
	filed within Hygiene. wher than "	S	10 0 asser	18. Mother's Name		nircraft aiden Surname)				
lan		To Be	John Edmond Jackson	Nellie V	iola Sho	emaker				
Maryland					City or Town, State, Zip Code)					
	1 and Heal Sm 2			2 Fairplay Road, Bo position (Name of matory or other place)		Md. 21713 Dc. Location - City or Town, State				
moi			1 💢 Buriai 2 🗆 Cremation 3 🗆 Removal from State	wn Mem. Park 10/2	4/09	Hagerstown, Maryland				
Baltimore,	permit. Page Department of Important: If any injury or once.			2. Name and Address of Facility MIN		ERAL HOME				
Ш	20 E 8 9		23a. Part 1. Enter the disease, or complications that caused the death. Do not er	15 E. Wilson Blvd.						
	Physician		shock, or heart failure. List only one cause on each line.	wal bleed	1	Approximate Interval Between Onset and Death				
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	1 rnonce						
	Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (of as a consequence of):	sion)	_ (/	year				
	uted 1 Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	mo ohe's	de	e. months				
oʻ	te be executed ysician and e burial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence of):	our of						
68760,	cate be	dical	d							
Box 6	leath certificate attending phys I for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery				
В.	death	sicial	in the past 12 months? 1 Yes 2 No 1 Very 2 No	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year				
P.0	that the dended by the a	Phys	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e Did toba	acco use contribute to the cause of death?				
Vital Records,	es De di	d by	Tarris Cities Significant Conditions contributing to detail but not recoming in the	and onlying oddoc given in Farti.	1 □ Yes					
eco	law requir as been si 2 should I	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of				
<u>=</u>	: The cate h	Com			performe	ed? death? Lend death? 2 □No				
Vita	sician: The certificate irector, pag	Be c	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No Hospital: 1 □ Inpatient 2 □ ER/Outpatie	26. Place of Death						
J Of	Attending Physician: or death. ector: After this certifica by the funeral director, p	n: To	27. Mannar of Death 28a. Date of Injury 28b. Time		28d. Describe how	injury occurred				
sio	ttendir death. ctor: Af y the fu	catic	2 Accident investigation	M 1 □Yes 2 □No						
Division	lor At after c Direc	Certification:	4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	City or Town,	eet and Number or Rural Route Number, State)				
	Hospital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check qnly 2 Medical Examiner: On the basis of examination and/or i							
	the hir the nple	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)				
	viti To		DA SPN MD	20045031		xl-212008,				
200	H 15+1		30. Name and address at person who completed cause of death (Item 23a) (Type	Distietan Stoce	of H	OMD DIZILA				
	Sta	te	5 HAVYB E SI BB7 OLY - 32 Y E (31. Date filed (Month, Day, Year) 32. Registrar's Signature	None and DIDE	((Va	J 110 2190:				
,	Registr		31. Date filed (Month, Day, Year) 2009 32. registrar's Signature	are a						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 35104

			for State Registrar		Otato	0	ylaria / E	Cer	tificate of	Death	w		Reg. N	2009	3316	J 4
	Dharisi		1. Decedent's Name (Firs	st, Middle, La	ıst)							2. Date of De		ay Year	3. Time of Dea	ath
	Physici /Medio		MAE	PEA	RL		JOHNS	ON				OCTOB	ER 1	17 2009	3:44 A	М
	Examir	er	4a. Facility Name (If not in	_					4b. City, Town, o		of Death			c. County of Death		
and the			WASHINGTO 5. Social Security Number				ITAL (In yrs. last bir	thday)	TAKOMA If Under 1 Year		24 Hrs.	8. Date of Bir	th	1ONTGOMER	Y place (State or Fo	oreian
ŀ,	Funeral Director		241-36-6275 Usual Residence of Dece	5	1 □ M 2 □XF	7.79	, ,	Yrs.	Months Days	Hours	Min.	(Month, Da	ay, Ye <i>ai</i>	1930 NORT	ntry)	
	yland how		10a. State 10b.	County			10c. City, Town	n or Loc	ation						10d. Inside City Li	imits
	a-f sh	ctor	MD PE	RINCE	GEOEGE '	S	CAP	ITAL	HEIGHT	5					1∭Yes 2□] No
	within 72 hours after death with the Marylan giene. r than "natural", or items 23a or 28a-f show the Madical Evaning must be notified at	al Director	10e. Street and Number 7103 VALLEY	Y PARK	ROAD				10f. Zip Code 207	43			10g. C	Citizen of What Cou SA	ntry?	
	r dear	Funeral	11. Marital Status		12. Was De Armed F	Forces?		13. V	Vas Decedent of Yes, specify Cub	Hispanic Or an, Mexica	rigin? (Spenn, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Ameri Black, White,		
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Evaninar must be notified at	by	1 ☐ Never Married 2 3 ☐ Widowed 4 🔀 🖸		1 ∐Yes If Yes, 0 Year or	aive Dates:			□Yes 2∏xNo		r:				LACK	
15-	"nati	Completed	15. [(Specify on	Decedent's E ly highest gr	ducation ade completed	1)	16a	(Give I	ent's Usual Occu kind of work done OO NOT use retire	during mos	st of worki	ng	16b. 	Kind of Business/In	dustry	
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þ	Hyger in	Be	17. Father's Name (First,	Middle, Last	")			Jene	1111	18. Moth	er's Name	(First, Middle				
Maryland		5 B	ALEX STEV	/ENS			PEARL WILLIS									
lar	and and street		19a. Informant's Name/F	, ,		THE P			ing Address (Street and Number or Rura VALLEY PARK ROAD (07/1
e, l	1 and Heal em 2 ther		JOHNSIE P.		S/DAUGE	ITEK						Date		Location - City or To		0/4
Baltimore,	permit. Pages Department of Important: If it, any injury or o		1 ☑ Burial 2 ☐ Cre 4 ☐ Donation 5 ☐ 0	mation 3 [n State			sition (Name of latory or other pla 'ION CEMI	i	10-2	3-09	CLI	NTON, MAR	YLAND	
Ball	permit Depart Import any in		21. Signature of Frincial	Service Lice	nsee				Name and Addr					IS FUNERA R,MARYLAN		
1	Physician physician and physician and as the burial-transit	cal Examiner	23a. Part 1. Enter the dis shock, or heart fail immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ure. List only	b	each line Rio o (or as a	е.	of):	Candio						Approximate interval Betwee Onset and Deat	th
.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Un												23d. Date of deliv Month	very Day Yea	.r
ds, P.	uires that signed b Id be deta	þ	Part II. Other significant End Sta	conditions	contributing to	~	t not resulting in	_	derlying cause gi	ven in Part	l.			o use contribute to to 2 ☐ No 3 ☐ Pro	V	
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į ×	ys dir	To Be	examiner? 1 ☐ Yes 2 🙀 No		Hospital: 1] Inpatie	nt 2 ER/O	utpatien	t 3 DOA Ot	hor:				6 ☐Other (Spec	ify)	
ion o	ding h. After fune		27. Manner of Death 1 Natural 5 2 Accident	Pending investigation	28a. Dat (<i>Mo</i>	te of Injur onth, Day	y ; Year) 28b.	Time of Injury	Wo	ıryat rk? ∃Yes 2.□	_]	28d. Describe	how inj	ury occurred		
Division	al or Attends after death	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	20e. Plat	ce of Inju Iding, etc	ry - At home, fa . (Specify)	ırm, stre	eet, factory, office			28f. Location (City or To		and Number or Rui ate)	al Route Number	r,
. /	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	Medical C			miner: On the		examination ar							e(s) and manner as and place, and due		
4	To the within 2 To the comple	Me	29b. Signature and title of	of certifier	n			0	P=-	se number				Date signed (Month)		
			Men	lh	nll	1/0	se hu	Y	حد ا	01	5	2	00	TOBERI	7,2009	<u> </u>
_	6		30. Name and address of PAUL A	0.1	1	use of de	eath (Item 23a)	(Type, F	Print) BQUE	ENSE	BURG	1 Rd F	140	tober1	MOSO	781
	Sta Registr	ite ar	31. Date filed (Month, Da	2009	32.	Registra	r's Signature	uks	1							

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) OCTOBER 13 2009 ar **Physician** 10:20 P_M LOUISE JACKSON COLLETTE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
DEC 12 1949 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday, 6. Sex **Funeral** Days Hours Min. Months 1 M 2 F 59 WASHINGTON, DC Director 218-54-5111 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Expiriment unit be notified at 1 XYes 2 No Director PRINCE GEORGE'S LANHAM MD10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20706 USA Funeral 1510 3rd STREET 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: BLACK Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT EDUCATOR 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LILLIAN LYNCH ပ PEYTON JACKSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1510 3RD STREET LANHAM, MARYLAND JOELLE JACKSON SWETT/SISTER permit. Pages 1 a
Department of He
Il portant: If item 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 Removal from State RIVERDALE, CREMATORY 10-26-2009 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE CREMATORY J. B. JENKINS FUNERAL HOME 21. Signature ral Service 22. Name and Address of Facility Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? Month Year detached for 5 Other (specify) 1 ☐ Yes 2 ☑ No P.O. the 9 🗆 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☒ No 2 🔀 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred spital or Attending P nours after death. ineral Director: After 1 y filled in by the funera 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MY 0 06042183 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 3001 HOSPITAL DRIVE CHEVERLY, MARTLAND 20785 KAREN R. BROOKS M.D. 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

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STATE

32. Registrar's agnatu

		-	For State of M	aryland / Depa <i>Cer</i>	artment of Hotelin of Description	ealth and M eath	lental Hygid Reg	ene 2009	35106				
	Physicia		1. Decedent's Name (First, Middle, Last) Alvin Kushner	2_			2. Date of Death Month Xtobea	Day Year	3. Time of Death				
	Medic Examin		4a. Facility Name (if not institution, give street and number) Washington Adventist Hospi	tal	4b. City, Town, or I			4c. County of Deat					
	Funeral Director		5. Social Security Number 219–28–3218	e (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bir 1927 Was	hplace (State or Foreign Righton, DC				
	rland f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc					10d. Inside City Limits				
	rtne Mary a or 28a- be notifie	Funeral Director	Maryland Prince George's 10e. Street and Number	College Pa	10f. Zip Code		10	g. Citizen of What Co	1 🖾 Yes 2 □ No untry?				
	eath with tems 23 er must	Funera	3507 Wofford Court 11. Marital Status 12. Was Decedent 1	Ever in U.S. 13. V	20740	panic Origin? (Spe	cify Yes or No-	Jnited Sta	rican Indian,				
9036	rs after d	by	1 Never Married 2 Married Armed Forces? 1 Never Married 2 Married 1 Neves 2 1 If Yes, Give 10 Year or Dates.	No	f Yes, specify Cuban I ☐ Yes 2 🛣No		Rican, etc.)	Specify: Wh	ite				
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant: If item 27 is marked other than "natural", or items 25a or 28a-f show amortant: Items in a should be a shou	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5)	(Give P	dent's Usual Occupa kind of work done du O NOT use retired)	tion uring most of worki	ng	6b. Kind of Business					
nd 21	filed with al Hygien d other t event, the	Be	17. Father's Name (First, Middle, Last)	Lawye			e (First, Middle, Ma		vernment				
Maryland	should be file h and Mental I 7 is marked o traumatic eve	욘	Benjamin Kushner 19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street ar	nd Number or Rura	Γ. Venezs [Route Number, Control of the control	ity or Town, State, Zip	Code)				
re, M	1 and 2 s f Health s item 27 i		Gail S. Kushner -Wife 3507 Wofford Court College Park, Maryland 20 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, St. cemetery, crematory or other place)										
Baltimore,	it. Page intment or intant: If injury or		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Arlington	National	Cemeter			gton,Virgini				
Ba	permit. Departr Imports any inju	1	21. Signature of Funeral Service Licenses Angle Boyeva						ryland20705				
4	Trysician/	2 5	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin immediate Cause (Final disease or condition		er the mode of dying	, such as cardiac c	r respiratory arrest	,	Approximate Interval Between Onset and Death				
-	Medical Examiner		(e	a consequence of):	tract	infec	him		Days				
	rted d ansit	Examiner	Sequentially list conditions, than leading to immediate cause. Enter Underlying Cause (Disease or linjury										
)	cate be executed physician and s the burial-transit	edical Ex	that initiated events resulting in death) Last	a consequence of):									
8760	tificate ing phy		IF FEMALE:										
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year				
s, P.O	ires that th signed by d be detac	þ	Part II. Other significant conditions contributing to death to Cardio my o Party	out not resulting in the u	ınderlying cause give	en in Part I.		cco use contribute to	the cause of death?				
Division of Vital Records,	e faw requirence has been ge 2 shou	Completed	Atrial Fiscillation Acute Renal Faile	٠			24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of				
a B	ian: The	Be Co	25. Was case referred to medical			ce of Death (Check	1 🗌 Yes 2	IZ No 1 ☐ Yes	3 2 X No				
of Vii	y Physic er this ce eral dire	욘	1 Yes 2 No 1 Nopat 27. Manner of Death 28a. Date of inju		28c. Injury	4 □ Nursing Ho at	me 5 Residence 28d. Describe how	ce 6 Other (Specinjury occurred	ify)				
sion (Attending death. ctor: Affe y the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Ini			′es 2 □ No	28f. Location (Stre	et and Number or Ru	ral Route Number.				
Div.	28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rura 28f. Location (S												
	the Hosp hin 24 ho the Fune	Medical	(Check 2 Medical Examiner: On the basis of e only one) 3 Certifying Nurse Practioner: To the	examination and/or invest	tigation, in my opinior death occurred at the	n, death occurred at time, date and plac	the time, date and e, and due to the ca	place, and due to the ause(s) and manner as	cause(s) and manner stated. stated.				
	20 20	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)											
						st Suite	25 Silv	er Spring	Maryland 2003				
	Sta Registra		31. Date filed (Month, Day, Year) OCT 2 0 2009 32. Registr	ar's Signature	New York								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	for State Registrar	State Of IV	iai yiai iu	Cer	tificate of E	ieaith and Death	ivientai my	/gien Rea. N	2009	35107				
	Physicia	n/	1. Decedent's Name (First, Middl	e, Last)					2. Date of Do	eath	lay Year	3. Time of Death				
	Medic Examin	al	4a. Facility Name (if not institution	Johanna M.	Kluger		4b. City, Town, or	Location of Dea		ber	15, 2009 c. County of Death	11:40 pM				
المديد	#	CI	Sunrise Assisted	,	er Spring	g		llver Spri		4	Montgomery					
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bi	rth	9. Birth	place (State or Foreign				
	Director		577-52-8763 Usual Residence of Decedent	1	82	Yrs.	,		April 0	4, 19	27	Germany				
	show d at	tor	10a. State 10b. County	,	10c. City, To	own or Lo	cation		<u></u>			10d. Inside City Limits				
	Mary 28a-f otifie	irec		ntgomery			F	Rockville			1 🗌 Yes 2 🕱 No					
	th the 3a or the n	al D	10e. Street and Number				10f. Zip Code			10g. C	g. Citizen of What Country?					
	ems 2	Funeral Director	4140 Great 0	lak Road 12. Was Decedent	Ever in U.S.	13. V	Vas Decedent of Hi	20853	Specify Yes or No	_	U.S.A. 14. Race - American Indian,					
စ္တ	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I Health amd Mental Hygiene. The show factor is and red other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Ma	If Von Civo			Vas Decedent of His f Yes, specify Cubar		to Rican, etc.)	Rican, etc.)						
21215-0036	ours a atural	Completed	3 X Widowed 4 Divorced	Year or Dates.						ucasian						
75	n 72 h an "na Medio	mpl	(Specify only high Elementary/Seconday (0-12)	est grade completed)		(Give I	lent's Usual Occupa kind of work done d O NOT use retired)	ation Juring most of wo	rking	16b. I	16b. Kind of Business Industry					
	l withii ygiene her th t, the		Liementary/seconday (0-12)	College (1-4 or 2	0+)		Registere	d Nurse			Neo-Natal Care					
Maryland	should be filed wit and Mental Hygie is marked other aumatic event, tt	To Be	17. Father's Name (First, Middle,					18. Mother's Na	, Maiden	faiden Surname)						
ڇ	should be and Mer is marke raumatic		Eri. 19a. Informant's Name/Relations	ch Voigt	1.	IOL Maili-	- Address (Carat	- 1111	Charlott							
	d 2 sh alth ar alth ar 27 is ertrau		Barbara C. Emanue				o Great Oak				City or Town, State, Zip Code)					
Baltimore,	le 1 and t of Heal If item 3 or other		20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation			e of Dispo	sition (Name of natory or other place	1	Date		_ocation - City or To	own, State				
<u>=</u>	t. Pag tmen tant: jury		4 Donation 5 Other (Specify)			oln Cremator		/21/2009	Bre	entwood, Ma	ryland				
Ba	permir Depar Impor any in		21. Signature of Facility 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20 23a. Part 1. Enter the disease, or complications that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw.													
Н			23a. Part 1. Enter the disease, or shock, or heart failure. List	r complications that cause	the death. D	o not ente	r the mode of dying	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between				
~ [hysician/		Immediate Cause (Final disease or condition	- ARTE	RIOSC	LENO	nc Cent	ets ro VI	HICHAR	Dis	EASE	Onset and Death				
-,4	Medical Examiner		resulting in death)	Due to (or as	a consequenc	ce of):										
		ner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequenc	ce of):		_								
В	cuted	Examiner	Cause (Disease or linjury that initiated events	с							16					
	cate be executed physician and the burial-transit	ä	resulting in death) Last	t Due to (or as a consequence of):												
8760	ificate be executed g physician and as the burial-transi	1edic		d					_							
~	ath certifica attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnancy	,			23d. Date of delive	ery				
Box	death cert the attendir	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify)	,			Month Day Year					
P.O.			Part II. Other significant condition						23e. Did t	obacco	use contribute to the	ne cause of death?				
ls,	uld be	Completed by	- PNEVMONI	A, ADVAN	ICO	DEN	NEWTI A	• •	1 🗆	Yes 2	No 3 □ Prol	pably 4 🗆 Unknown				
000	aw rec as bee 2 sho	plet	HTN, PAG	LICINSON'S	D15	EAS	E		24a. Was auto			osy findings available mpletion of cause of				
<u>۾</u>	: The I cate h ; page								perfo	rmed?	death?					
Vital Records,	sician certif	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Othor	ce of Death (Che				ASSISTM LIVI				
6	ng Phy ter this neral c		27. Manner of Death	28a. Date of inju		outpatien Time of injury	28c. Injury	at	dome 5 ☐ Resident 128d. Describe I		Other (Specify ry occurred	, 1-21-1, 20 -1, 7, 7				
o o	tendir death. tor: Af the fu	Certificate	1 Natural 5 Pendir 2 Accident Investi 3 Suicide 6 Could	gation				Yes 2 No								
Division of	l or At after of Direct I in by	Sel	4 Homicide determ		ury - At home, c. (Specify)	farm, stre	et, factory, office		28f. Location (S City or Tov		nd Number or Rural e)	Route Number,				
29a. Certifier (Check only one											nd manner as state	d.				
											use(s) and manner stated. ated.					
	P ≥ P S		29b. Signature and title of certifier	roundar	,		29c. License	number 3 3 6 7		29d. Da	ite signed (Month, L	Oay, Year)				
	4		30. Name and address of person	who completed cause of d			rint) SHY		MOAD	RA	JANI	/ '				
			9801 GEOR	GIA AVEN		SVIDE	:117, '5	1 wears	onjag,	M	DAN D: 2090	2				
	Stat Registra	-	31. Date filed (Month, Day, Year) OCT 2 0 2	nng lengist	are signature	park	2									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	•	State Registrar An	nend#3,	10-2	23-09	perDr	.HCHI	Cert	ficate of	Death	1 1410	111241 1198	Reg. No	201	09	35108		
Physicia	n/	1. Decedent's Nam Wing K	e (First, Middle, wan	Last)						· · · · · · · · · · · · · · · · · · ·		Date of Dea	ath		Year	3. Time of Death		
Medic Examin		4a. Facility Name (if	•	give stre	eet and num	nber)			4b. City, Town, o	or Location of Dea		CCODCI		County o		1 3:43 AM		
		Gilchris 5. Social Security N				7 Ass //p :	m last him	th aloud	Towson If Under 1 Year	If Under 24 H	ro 0	D-t(Dist		altin				
Funeral Director		451-65-3		6. Sex	M 2 □ F	7. Age (In yi	rs. Iast bin 81	Yrs.	Months Days	If Under 24 Hi Hours Mil		Date of Birth (Month, Day ept 15	h <u>(</u> Ye <i>ar</i>)	928	9. Birthp Coun hin	olace (State or Foreign try) a		
nd how at	۲	Usual Residence of 10a. State	Decedent 10b. County			10c.	City, Tow	n or Loca	ition							0d. Inside City Limits		
Maryla 28a-f s otified	Director	MD	Howard			Co.	lumbi	a								1 Yes 2 No		
with the s 23a or 2	Funeral Di	10e. Street and Nur 6173 Si		rows	. Way	•			10f. Zip Code 21045					0g. Citizen of What Country? hina				
r death		11. Marital Status	X		Armed For	edent Ever in	U.S.	13. W	as Decedent of H Yes, specify Cub	lispanic Origin? (an, Mexican, Pue	Specify erto Rica	Yes or No- an, etc.)		14. Race	- Americ			
ırs after ural", o I Exam	ted by	3 Widowed		ea	1 ☐ Yes If Yes, Give Year or Da	re		1	☐ Yes 2 🗓 No	Specify:			Specify: Asian					
in 72 hou e. ian "nati Merica	Completed	(Spe	15. Deceden ecify only highes onday (0-12)				16a	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						16b. Kind of Business Industry				
ed withi Hygien other th	Be Co	1		aet)			Ch	Chef Restaurant 18. Mother's Name (First, Middle, Maiden Surname)										
d be file Mental arked c	힏										rst, ivildale, i	iviaiden s	Surriarrie)					
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuny or other traumatic event, the Me Teal Examiner must be notified at once.		19a. Informant's Na Doris Le							ling Address (Street and Number or Rural Route Number, City or Town, State, Zip 3 Silver Arrows Way Columbia, MD 2104									
age 1 and ant of Hea ht: If item y or othe	İ	20a. Method of Disp	Cremation	3 🗆 Re	emoval from	State	cemete	ry, crema	tion (Name of tory or other pla	matory 1	Date					own, State		
permit. Pa Departme Importan any injun once.	ł	4 ☐ Donation 21. Signature of Fu	5 Other (S)		011	<u> F 1</u>	Lilai							dbine P.O.	<u> </u>			
		21. Signature of Funeral Service Licenses Golffigan Hollies Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate																
Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition One tand Death One tand Death														Interval Between		
Medical Examiner		resulting in death)	n l	a .	Due to ((or as a cons			VII /C C			-		-		46017 5		
	iner	Sequentially list co if any, leading to in cause. Enter Unde	nmediate 🌙	b.	Due to (or as a cons	sequence	of):							+	-		
recuted and li-transi	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last C. Due to (or as a conseq						of):							+			
sate be executed physician and the burial-transit	Medical			L d.											4			
certifica nding p use as t		IF FEMALE: 23b. Was decedent	pregnant	230	c. If yes, out	come of pre	gnancy			_				23d Date	of delive	en/		
ne death certi / the attendin ched for use	Physician/	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 Live I 4 Pregr 9 Unkn		3					23d. Date of delivery Month Day Year							
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ক্র	Part II. Other signif	ficant condition	ns contr	ibuting to de	eath but not	resulting	in the und	derlying cause g	iven in Part I.		23e. Did to		/		ne cause of death?		
law requ has been je 2 shoul	Completed											24a. Was a		24b. We	ere autor	osy findings available mpletion of cause of		
sician: The la certificate ha rector, page		25. Was case referr	and to medical	_								perfor	med? 2 No	de	ath?	2. No		
lysician lis certi directo	To Be	examiner?	No	Hos	spital:	Inpatient 2	ER/O	utpatient	Oth	lace of Death (Ch ner: 4 \(\sum \) Nursing			ence 6	Other	(Specify	, to spice		
ding Ph th. After th funeral		27. Manner of Deatl 1 Natural 2 Accident	h 5 🗌 Pending Investig		28a. Date of (Mont	of injury th, Day, Year,		Time of njury	28c. Injui wor M 1	ry at		. Describe h				0		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	3 Suicide 4 Homicide	6 Could r determi	not be		of Injury - A		rm, stree	t, factory, office		28f.	Location (S City or Town			or Rural	Route Number,		
Hospita 24 hours Funeral sted filled	Medical	29a. Certifier 1 (Check 2	☐ Medical Ex	xaminer	r: On the bas	is of examina	ation and/o	or investig	ation, in my opini	e, date and place ion, death occurre	d at the	time, date ar	nd place,	and due to	o the cau	use(s) and manner stated.		
To the within To the comple		29b. Signature and	title of certifier				1		29c. Licens				29d. Dat	e signed (Month, I	Day, Year)		
			8 Hi		WIM	D			7 7	0059	44	7	101	171	J4			
2		30. Name and addr			pleted caus	e of death (I	tem 23a) (lype, Pri	v. To.	uson to	V/	61V	1	10 m	1500	, 40 2 12dy		
Stat Registra	Е	31. Date filed (Mont	OCT 20	200	9 32.	agistrar's Sig	gnature.	Spa	aled									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

1 - For State Registrar

	Physici	an	1. Decedent's Name (First, ELSIE	Middle, La	,	KNOT						OCTOBER 23 2009 3. Time of Deal			3. Time of Death
	/Medi											OCTOB			
	Examir	ner	4a. Facility Name (If not ins				VIUID	4b. City, 1			of Death		1	ounty of Death	
	Funcasal		5. Social Security Number	6. 5			lN I K . last birthday)	If Under	PLA 1 Year	If Under	24 Hrs.	8. Date of Bi	rth	HARLE:	place (State or Foreign
1	Funeral Director		268-22-873		I □ M 2 🔀 F	93	Yrs.	Months	Days	Hours	Min.	APR.	7, 191	6 OH.	IO
	put 🔏		Usual Residence of Deceder 10a, State 10b, C			10c Cit	y, Town or Lo	cation							10d. Inside City Limits
	sho	٥		RLES	S	1	NDIAN)						1 ☐ Yes 2√D(No
	28a-1	Director	10e. Street and Number					10f. Zip	Code				10g. Citize	en of What Cou	
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evaninar rout be notified at		4415 HAWTH	ORNE	ROAD				064	0				S. A	,
	ems series	Funeral	11. Marital Status		12. Was Deceder Armed Forces	nt Ever in U.	S. 13.	Was Decede	ent of Hi	spanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.		
36	or its	by Fu	1 Never Married 2		1 □Yes 🛂	₹ No	1	1 □ Yes 2		Specify:		1 110471, 010.7		necify:	
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215	in 72 n "na"	Completed	(Specify only		ade completed)	-	(Give	kind of worl DO NOT use	k done d	uring mos	t of work	ing	100. Killo	I OI Dusiiless/ii	idustry
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yla	should be and Mental s marked o umatic eve	ဥ	CLYDE W.	COON	TZ					OSA	E.	YOKUN	1		
Maryland	2 sho h and is ma rauma	W i	19a. Informant's Name/Rel JUNE BONIF			ED.	T		,					Town, State, Zi	,
	s 1 and 2 of Health item 27 i		20a. Method of Disposition	EK /	DAUGIT		Place of Dispo			1				MD 206	
nor	Pages nent of int; If its iry or o		1 Burial 2 ☐ Crem			to 0	cemetery, crei	matory or ot	her place			ÖBER 2009			
altimore,	fert.		4 □ Donation 5 □ Ot 21. Signature of Funeral Se			11.		2. Name and			_	-	-	-	MARYLAND
ñ	Depa Impo any ir	W	for	RO	ASL	MO0					UW	AVE.,	LA P	.SERV. LATA,	CE,P.A. MD 20646
			23a. Part 1. Enter the disea shock, or heart failure	se, or com			h. Do not en	ter the mode	e of dying	g, such as	cardiac	or respiratory	arrest,		Approximate Interval Between
Town .	Physician		Immediate Cause (Final disease or condition		Lef-	+ 000	cipit	al F	DRIVE	etal	()	emor	1296	2	Onset and Death
	/Medical Examiner		resulting in death)		Due to (or a	as a conseq	uence of):	11050	OA					- 9	Year -
	Lxammer	1	Sequentially list conditions,		b			1(7.0)							(6-6)
	uted nsit	nin	any, leading to inintediate cause. Enter Underlying Cause (Disease or injury	~	Due to for a	as a conseq	uence on.								
,	execting and ial-tra	Examiner	that initiated events resulting in death) Last		Due to (or a	as a conseq	uence of):								
68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			l	_ d										
89	ertifica ing ph e as th	Med	IF FEMALE:										· · · · · ·		
Вох	ath ce	ian/	23b. Was decedent pregna in the past 12 months		23c. If yes, outcon	n 2 ☐ Feta	Ideath 3	Ectopic pr	regnancy	,			23	d. Date of deli-	very Day Year
P.O.	the de	Physician/Medical	1 □ Yes 2 ☑ No 9 □ Unknown		4 ☐ Pregnan 9 ☐ Unknowr	t at time of d	ieath 5L	Other (spe	ecity)						•
σ,	that ned b deta		Part II. Other significant co									23e. Did	tobacco use	e contribute to	the cause of death?
of Vital Records,	quires	ed by	COPD,	TYF	PE 2 D	(ABE	TES	MEL	417	205		1 🗆	Yes 2	No 3□ Pro	bably 4 🗍 Unknown
ဝ၁	aw re	Completed	HYPE	RTE	NSION							24a. Was		24b. Were aut	opsy findings available ompletion of cause of
Ä	The late has	mo.										auto perfe 1 □ Yes	ormed?	death?	
/ita	cian: ertific	Be	25. Was case referred to m	edical						26. Place	of Deat	n (Check only			
) T	hysic this or	ဥ	1 ☐ Yes 2 ☐ No				ER/Outpatie			4 🗷 NI				☐ Other (Spec	ify)
J.	ing F I. After funera	io		ending		njury Da <i>y, Year)</i>	28b. Time o Injury	f 28	Bc. Injury Work			28d. Describe	how injury	occurred	
Division	death ctor: y the	licat	3 ☐ Suicide 6 ☐ C	ould not b	e lago Place of I	lniurv - At ho	ome, farm, str			/es 2□	-	28f. Location	(Street and	Number or Bu	al Route Number,
Σį	after after Direct	Certification:	4 ☐ Homicide	etermined	building,	etc. (Specif	y) (12.11.1, 6.1.	oot, laotory,	omoc			City or To	wn, State)	realized or real	ar riodio ridinaci,
	ospita hours ineral		29a. Certifier 1 Ce	rtifying Pl	nysician: To the be	st of my kno	wledge, deat	h occurred a	at the tim	ne, date ar	nd place,	and due to the	e cause(s) a	and manner as	stated.
	the He hin 24 the Ft	Medical	(Check only 2 Me	dical Exal	miner: On the basis and manner	stated.	ttion and/or ir	ivestigation,	in my op	oinion, dea	atn occur	red at the time			
_	5 + 1 = 2	Σ	29b. Signature and title of o	ertifier	emdher.	nt				number				signed (Month	Day, Year) 2009
	1								1580)313	60		09	000	7 ,400 !
	101		30. Name and address of p		6 Post				1j†4	≥ 10°	1 W=	ldorf	. Mai	cvland	20601
	Sta	te	31. Date filed (Month, Day,	Year)	32. Fegis	strar's Signa	ture			- 10	. ,,,	.14011	, Hai	- y rand	20001
	Registr		NOV	022	009 An	m	1. 4	and	D						
DHI	MH 17 Rev 1/2	001					¥ 6								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009

Certificate of Death Reg. No.

35109

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, 🤝

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 10

	1 - State Registrar		Certifica	te of Death	Reg. I	No. 2009	35110
n al	Decedent's Name (First, Middle, Last) Bernard	LOCKE	R		2. Date of Death Oct. 26,	2009 Year	3. Time of Death 4:35 A. M
er	4a. Facility Name (If not institution, give stree 9707 Old Georgetowr	n Rd	Ве	, Town, or Location of Dea thesda		4c. County of Death Montgomer	
	5. Social Security Number 217-30-3306 6. Sex 1X M	2□ F 7. Age (In yrs. last	Yrs. If Und	er 1 Year If Under 24 Hrs Days Hours Min	April 28,	9. Birthp 1908 New	olace (State or Foreign
ctor	10a. State Montgomery	10c. City, 7 Be	own or Location thesda				0d. Inside City Limits 1 ☐ Yes 2 ☑ No
ral Dire	9707 Old Georgetown	Rd. #2216	10f. Z	20814	10g.	Citizen of What Cour	ntry?
by Fune	1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates:	13. Was Dec If Yes, sp 1 □ Yes	edent of Hispanic Origin? (ecify Cuban, Mexican, Puel 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
Be Completed by Funeral Director	15. Decedent's Educatio (Specify only highest grade coi Elementary/Secondary (0-12)		16a. Decedent's Us (Give kind of w life, DO NOT Owner	ork done during most of wo	rking 16b	. Kind of Business/In Books	dustry
To Be C	17. Father's Name (First, Middle, Last) Sigmund Locker	•		18. Mother's Na	me (First, Middle, Maid Ni Scheir	den Surname) 1	
	19a. Informant's Name/Relationship (Type. If Barbara Frumkin / 20a. Method of Disposition	daughter		ss (Street and Number or F	ace, Potom		0854
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	cem	David Mer	n. Gard. Oct	27, 2009	Falls Chui	rch, Va
	21. Signature of Funeral Service Licensee	ZyCe	254 C	and Address of Facility To arroll St., N	WW, Washing		0012
	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call Immediate Cause (Final disease or condition resulting in death)	ons tijat caused the death. ausejon each line. Congestiv Due to (or as a consequer	e Heart		ac or respiratory arrest,		Approximate Interval Between Onset and Death
Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consequer					
	in the past 12 months?	If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 🗆 Ectopic			23d. Date of deliv Month	ery Day Year
Completed by Physician/	Part II. Other significant conditions contribu	uting to death but not resulting	ng in the underlying	cause given in Part I.		co use contribute to t	he cause of death?
Complet					24a. Was an autopsy performed 1 ∐Yes 2 □	Drior to co	opsy findings available mpletion of cause of
Be	25. Was case referred to medical examiner?				eath (Check only one)		
	1 ☐ Yes 2 ☐ No Hosp	1 Inpatient 2 EF	R/Outpatient 3 🗌	OOA Other: 4X Nursing	Home 5 Residence		fy)
Medical Certification: To	Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28 28e. Place of Injury - At home	Bb. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	njury occurred t and Number or Run	ol Pouto Number
Certi	4 Homicide determined	building, etc. (Specify) an: To the best of my knowle			City or Town, S.	tate)	
l edica	(Check only 2 Medical Examiner: one)	On the basis of examination and manner stated.	n and/or investigati	on, in my opinion, death oc	curred at the time, date	and place, and due t	o the cause(s)
2	29b. Signature and title of continer	(19)	0	9c. License number D26259		pate signed (Month, ct. 26, 20	
	30. Name and address of person who compl Ava Kaufman, MD	821	18 Wiscon	sin Ave., Be	thesda, Md		
e	31. Date filed (Month, Day, Year) 0CT 28 2009	2. Registrar's Signatur	faces				

Sta Registr

09-07826											opies Are L	egible	e.	
Emeterio Moreno		na i- For State	St	ate of	Maryland	-	rtment tificate			d Ment	al Hygiene		20	09 3511
Physicia		Registrar 1. Decedent's Nam	ne (First, Midd	le.Last)			lilicale	oi Deal			2. Date of D	Reg. No.		3. Time of Death
Medical Examin		Emeter		ari	no Li	ına					Month October			1319 hrs
		4a. Facility Name (4800 Rhod			treet and number)			Town, or tsville	Location of	f Death		c. County of Dea Prince Georg	
Funeral		5. Social Security I		6. Sex	7. A		ast birthday)	If Und	der 1 Year				I/DD/YYYY) 9. E	Birthplace (State or
Director		577-25- Usual Residence of		1 X M	2F	28		Yrs.	lis Day.	110010	3/2	5/19	181	Domincan Rep.
v any	İ	10a. State	10b. County				Town or Lo							10d. Inside City Limits
yland -f shov	Ę	MD 10e. Street and Nu		e G	eorge's	<u> </u>	нуат	tsvi]	b Code			T10g Cit	tizen of What Co	1 Yes 2 X No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Realth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director			ort	h Avenu	ıe			781			ľ		Republic
h with	Funeral	11. Marital Status	o 🗆		Was Deceder Armed Forces						in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Am White, etc.	erican Indian, Black,
er deat		1 Never Marr 3 Widowed		1 1	Processing and the same of the	X No	1 ,	X Yes 2			nican Re	ep.	Blac Specify:	k
ours afl	d b	15. Decedent's E		0	r Dates:	mpleted)	16a. Dece		I Occupat	tion (Give k	ind of work done	16b.	Kind of Busines	
36 in 72 h	Completed	Elementary/Sec 1 0	ondary (0-12)		College (1-4 or	5+)		chani		. DO NOT	ase retired)	A	utobod	y Shop
215-0036 be filed within 7 ntal Hygiene. ked other than ent, th. M dica	E S	17. Father's Name	(First, Middle	, Last)						18.Mother's	s Name (First, Midd			у впор
1215 be file ental H rrked ovent, tl	a	Emeter								Mar	ia Sebas	stia	na Guz	man
MD 2' d 2 should Ith and M n 27 is m;	۵[19a. Informant's N Emeteri				athe					th Avenu			ate, Zip C2d0 781
e, M 1 and 2 Health item 2 r traun	ŀ	20a. Method of Dis	sposition			20b.	Place of Dis crematory o	position (Na	ame of ce		Date	20c	. Location - City	or Town, State
MOFE, Pages I an rent of Hea ant: If ite			X Crematio		Removal from S	ch Ch	esap	eake	Cre	m.	10/17/20	009	Beltsv	ille,Mđ
Baltil permit Departm Importa		21. Signal of Fi			9		2	PHTL	d Addres	s of Facility RIN	ALDI FUI	IERA	L SERV	ICE,P.A.
Physician	\dashv	23a. Part I. Enter t	he diséase, o	r complica	ations that cause	d the death	. Do not ent	9241 er the mode	COL of dying,	umbi , such as ca	a BIVd.S ardiac or respiratory	arrest, sh	rer Spr hock, or heart	ing Md2091 (Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause		1.1	line. ead Injuries		_							Death
, xammo		or condition result		Du b.	e to (or as a con	sequence o	of):							
	ner	Sequentially list or if any, leading to i cause. Enter Und	mmediate	Du	e to (or as a con	sequence o	of):					-		
B _B	Examiner	(Disease or injury events resulting in	that initiated	C	e to (or as a con	sequence o	of):		-				• • • • • • • • • • • • • • • • • • • •	
executed an and al - transit	ल	UNPENDE)	d	AMENDED									
68760, certificate be nding physici se as the buri	/Med	IF FEMALE:	t prognant in t	ho	23c. If yes, outco	ome of preg	nancy	-				2	3d. Date of deliv	-
x 68 h certifi ending use as	sician/Medic	23b. Was deceden past 12 month	is?		1 Live birth 4 Pregnant a	at time of de	2 eath 5	Fetal death Other (Sp		Ectopic	pregnancy		Month	Day Year
Box he death c	Phys	1 Yes 2			9 Unknown	ath house mass	anultina in t	he underlyis	22 221120	given in Po	urt 23e D	id tobacc	o use contribute	to the cause of death?
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be ex After this certificate has been signed by the attending physician luneral director, page 2 should be detached for use as the burial	þ	Part II. Other sign	illicant condi	itions c	ontributing to dea	ith but not i	resulting in t	ne underlyn	ng cause	giveiriii ra				Probably 4 V Unknown
ords w requi	Completed											utopsy	prior	autopsy findings available to completion of cause of
Reco	E I											erformed es 2		
ician: s certifi rector,	Be	25. Was case refe examiner?	erred to medic		spital:	ient 2	ER/Outpat	ient 3	26.Plac	e of Death Other	(Check only one) Nursing Home 5	Resi	dence 6 🗸 O	ther: Scene
n of Vital Records, fing Physician: The law require. After this certificate has been si funeral director, page 2 should b	1.1	1 ✓ Yes 27. Manner of Dea	2 No ath		28a Date of In	iurv	28b. Time	of Injury		ury at Work	? 28d. Descr	ibe how i	njury occurred t struck by tr	
ion ttendin death. rtor: A	atio	 Natural Accident 		nding estigation	FOUND: Oct 8, 2009		FOUND 1344 hrs	3		Yes 2 ✔	No			
Division tall or Attendin sts after death.	Certification:	3 Suicide		uld not be ermined	28e. Place of (Specify) ra			street, facto	ry, office	building, et	or Tov	n, State)		Rural Route Number, City attsville, MD
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be exprised to the the theorem of the this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	cal Ce	4 Homicide 29a. Certifier (Check only one)		hysiciar	: To the best of	my knowled	dge, death o	ccurred at the	he time, c	date and pla	ace, and due to the courred at the time, or	cause(s)	and manner as	stated.
	Medical	one) 2 💌		а	nd manner state					se number				Month, Day, Year)
3	_	11	1	114 -	K: 01	TO	m)		O.C	.M.E.	OCME	0	ctober 9, 20	09
		30. Name and add			mpleted cause of Assistant			r 111 F	Penn S	treet, Ba	Iltimore, MD 21	201		
		31. Date filed (Mo	nth. Dav Year)	82. Regist	rar's Sign		Ked						
Regis		00	AUZ	2009	Serena	1 14.	yan				<u> </u>			

	Tor AMEND#19coerFH, 10-18-09, BME, NO. 10-18-09, BMW, MocGo	artment of Health and Me ertificate of Death	ntal Hygiene 2009 35112
Physician	1. Decedent's Name <i>(First, Middle, Last)</i> Ruth Levine	2.	Date of Death Month Ctober 15, 2009 3. Time of Death 4:24
/Medical Examiner	4a. Facility Name (If not institution, give street and number) Nightingale House	4b. City, Town, or Location of Death Gaithersburg If Under 1 Year If Under 24 Hrs. 8,	4c. County of Death Montgomery Date of Birth Month Day (Sar) 9. Birthplace (State or Foreign
Funeral Director	5. Social Security Number 050-14-9067 6. Sex 7. Age (In yrs. last birthday 7. Age (In	Advisor Davis Harris Advis	uly 28 1921 New York
within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show he Modeal Examination in that be notified at the modeal Director ompleted by Funeral Director	10a. State 10b. County 10c. City, Town or L MD Montgomery Gaithersh		10d. Inside City Limits 1 □ Yes 2 □ No 10g. Citizen of What Country?
fiter death with the Mar r items 23a or 28a-f sh ther must be notified Thereal Director	10e. Street and Number 13004 Darnestown Road 11. Marital Status 12. Was Decedent Ever in U.S. 13	20878 Was Decedent of Hispanic Origin? (Specif	U.S.A.
ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Moteal Exemple is neithed at To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give X Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rio 1 ☐ Yes 2 No Specify:	Specify: White
ed within 72 hou ygiene. her than "natura t, the Modeal E. Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) caurant Worker	16b. Kind of Business/Industry Restaurant
2 should be filed within and Mental Hygiene. is marked other than aumatic event, the M. To Be Comp	17. Father's Name (First, Middle, Last) Samuel Dukoff		First, Middle, Maiden Surname) Shostak
1 and 2 should Health and Mer tem 27 is marke other traumatic		ing Address (Street and Number or Rural F Sworthy Terr. North	Route Number, City or Town, State, Zip Code) 20878 Potomac, MD 20828
Pa In in it.	4 □ Donation 5 □ Other (Specify) National	osition (Name of Date matory or other place) L Crematory 10/20/	2009 Falls Church, VA
permit. Departr Importe any inju	Jane No 1977	1091 Rockville Pike.	d Sagel Funeral Direction, Rockville, MD 20852 INC.,
Physician /Medical	2% Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Alzheimer's Dispuse to (or as a consequence of):		respiratory arrest, Approximate Interval Between Onset and Death Approximate Setween Onset and Death
physician and ithe burial-transit and icas Examiner	Sequentially list conditions, if any, leading to immediate case. Ent II Jorgan Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c		
The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the completed by Physician/Medicompleted		☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year
quires that t en signed by uld be detact	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 র No 3 ☐ Probably 4 ☐ Unknown
			24a. Was an autopsy performed? 1 □ Yes ★★★ 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
ician certifi ector	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death (
er fe	1 Yes 2 No rospital: 1 Inpatient 2 ER/Outpati 27. Manner of Death 11 Natural 5 Pending 2 Accident Accident Rose Residue 1 Pending Investigation Rose Residue 2 ER/Outpati 28b. Time Injury	4 Nursing Home	e 5 Residence 6 Other (Specify) d. Describe how injury occurred
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28	f. Location (Street and Number or Rural Route Number, City or Town, State)
o the Hospita ithin 24 hours of the Funera ompletely fille	29a. Certifier (Check only one) **Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, an investigation, in my opinion, death occurred	nd due to the cause(s) and manner as stated. If at the time, date and place, and due to the cause(s)
To the within compare the comp	29b. Signature and title of certifier	29c. License number D09834	29d. Date signed (Month, Day, Year) October 19, 2009
F	30. Name and address of person who completed cause of death (Item 23a) (Type	Farragut Ave. Vocati	ngton MD 20905 2110
State Registrar	Barry N. Rosenbaum, M.D., P.A. 3720 31. Date filed (Month, Day, Year) CCT 2 0 2009	week Rensi	ngton, MD 20895-2110

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician Santina October 17 2009 0950 M Leemans /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Spring Montgomen Brooke Grove Rehabilitation and Nursing Center Sand If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day,) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□M 2 Days 1915 Washington, DC 93 579-16-8318 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐Yes 2X No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 72 hours after death with 20906 12811 Teaberry Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 21 If Yes, Give Year or Dates: 1 Never Married 2 Married or Baltimore, Maryland 21215-0036 1 ∐Yes 2 Z¥No Specify Specify: White à 3 Midowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Je filed wit. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Health and Mental Hygie tem 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Rinaldi Mary Mazzachi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane L. Kelley/Daughter 12811 Teaberry Road, Silver Spring, MD 20906 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of h Important: If ite any Injury or oth 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oct Gate of Heaven Cemetery 2009 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Immediate Cause (Final **Physician** pheumonia backerial disease or condition resulting in death) /Medical Due to (or as a conseque ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): physician the burial Box 68760. Physician/Medical attending p for use as t IF FEMALE: yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Fctonic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 ☐ Other (specify) signed by the a o 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy this certificate 2 No 1 ☐Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Division Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director; / 2 Accident 6 Could not be 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated To the I within 2

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

DHMH 17 Rev 1/2001

29c. License number

School Road Sandy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 6:12P M OCTOBER 25 2009 HELEN KEEHN LAWLOR 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death CHARLES 910 HICKORY CIRCLE PLATA LA Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 ☐ M 2 🕮 F Yrs. 202-20-7562 APR.24.1926 PENNSYLVANIA 83 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No CHARLES LA PLATA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20646 910 HICKORY CIRCLE U. S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐Yes 2 XNo Specify WHITE 3₺ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) COUNTY DRUG DRUG STORE OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WARREN KEEHN BERTHA MATILDA SCHAEFFER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DAUGHTER 912 HICKORY CIRCLE LA PLATA, MD 20646 JANIS LAWLOR / 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition OCTOBER 1 ☐ Burial 2XX remation 3 ☐ Removal from State METRO. CREMATORY 27, 2009 ALEXANDRIA, VA 4 Donation 5 Dother (Specify) 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 21. Signature of Funeral Service Licensee miso M006415635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mishock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as consequence of): ona Due to (or as a consequence of): ves, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 🗆 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No g Unknown

Physician /Medical **Examiner**

injury or

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

Be

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Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at

Hygiene.

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other

within 72 hours after death

Baltimore, Maryland 21215-0036

Examine and burial-trar attending physician Physician/Medical the as use or the signed by þ pe Completed peen

page 2 s

completely filled in by the

Be

Certification: To

Medical

certificate has

Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica

24 hours a

within 2.

requires that the death certificate be executed

Box 68760

P.O.

Division of Vital Records,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No 4 T Unknown

24a. Was an autopsy 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical	1			26. Place of Dea	th (Check onl. one)	
examiner? 1 Yeş 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 □ DOA	Other: 4 I Nursing H	ome 5 Residence	6 ☐ Other (Specify)
27. Man r of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury			28d. Describe how inj	ury occurred

2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the control of 29a, Certifier stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated.

29d. Date signed (Mghth, Day, Year). 29b. Signature and title of certifier 29c. License number

Name and address of person who completed cause of GL UN

31. Date filed (Month, Day, Year

ON

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October 17, 200^{Year} **Physician** 1:30A. M McElwain Katherine L. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Ceorge's Renaissance Cardens at Riderwood Village Silver Spring If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year Aug. 2, 1917 Birthplace (State or Foreign
Country) Social Security Number 6. Sex **Funeral** Days Hours South Dakota 322-16-8423 92 1 □ M 2X F Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Eventium is ust be multimed at 1 □Yes 2 No Silver Spring Maryland Prince George's Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Eventrum", ust by nonce. 20904 United States 3160 Gracefield Road, RC1405 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1∐Yes 2∭XNo Specify: ģ 3 Widowed 4 □ Divorced Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Librarian Public Library 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hugh Gardner Ruth Speicher ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1555 Hugo Circle Silver Spring, Maryland 20906 Angela M. Bednarczyk -Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Prospect Hill Cemetery 10/25/2009 Flemington, N.J. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bonard VoreBorgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or compocations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CVA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dementia -end stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c, if yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ Wo 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Hospital or Attending Physician: The law requires that the death Month Day Year 5 ☐ Other (specify) signed by the a Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2X No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has director, page 2: autopsy performed? 1 □ Yes 2 🖾 No 1 ☐ Yes 2 🕅 No this certificate Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal completely within 2 PRINCE PRACTIDINE And manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2d Silver Spring, HD 31. Date filed (Month, Day, Year) State 20 OCT Registrar

09-08189 John McAndrew Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 35116

,,,,,	MOAIGIEW		- For State Certificate C		Reg. No	
	Physicia	ın/	Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month Day October 21, 20	3. Time of Death
ledi	ical Exami		John McAndrew 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		lc. County of Death
			St. Agnes Hospital	Baltimore		
	Funeral Director		5. Social Security Number 220-46-0384 6. Sex 1 Age (In yrs. last birthday) 6. Sex 1 Age (In yrs. last birthday) 6. Sex 1 Age (In yrs. last birthday) 6. Sex 1 Age (In yrs. last birthday)	Months Days Hours Min.	8. Date of Birth (MN Jan. 22,	WDD/YYYY) 9. Birthplace (State or Foreign Country) 1949 Maryland
	any	F	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits
<u> </u>		٦	Maryland Cecil	Rising Sun		1 Yes 2 X No
700	th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 22 North Hills Drive	10f. Zip Code 21911		itizen of What Country? U.S.A.
	0036 within 72 hours after death with the Maryland within 42 hours after death with the Maryland free than "natural", or items 23a or 28a-f sho free than "natural", or items to notified at once. Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	Vas Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto R Yes 2 XX No specify:	cify Yes or No- tican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
	urs after tural", aminer	ã	or Dates:	lent's Usual Occupation (Give kind of wo most of working life, DO NOT use retire	ork done 16b	b. Kind of Business/Industry
	16 n 72 ho nan "na ical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Self-Employed		ainting Contractor
	5-0036 led within 72 Hygiene. lother than 'the Medical	mo	Two Years Pa	inting Contractor		
	21 be fi ntal rked	æ	John McAndrew	LIIZa ling Address (Street and Number or R	beth Foss	
	MD 2.	5	19a. Informant's Name/Relationship (Type, Print) William D. Fossett (uncle) 19b. Mai	Box 1051, Colora	, Marylan	id 21917
	t it is a		1 Burial 2 X Cremation 3 Removal from State crematory or	position (Name of cemetery, other place) ris & Co., Inc. 10/1	l W	c. Location - City or Town, State lest Chester, Pennsylvania
	Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr		21. Signature of Funeral Service Livens e	2. Name and Address of Facility	Son Fune	eral Home, P.A.
		70. //	23a. Part I. Enter the disease, or complications that caused the death. Do not ent	Perryville er the mode of dying, such as cardiac or	Maryland respiratory arrest,	21903-0766 shock, or heart Approximate Interval
	Physician	5 8	failure. List only one cause on each line. Immediate Cause (Final disease a Heroin intoxicatio			Between Onset and Death
	caminer		or condition resulting in death) Due to (or as a consequence of):			
		her	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):			
U	_	Examine	(Disease or injury that initiated events resulting in death) Last			
	760, icate be executed physician and the burial - transit	la E	d. 23a,27,28a-1	,permE, g897 11/6/	/09 TT 	
	60, ate be ex shysician te burial	Medical	X UNPENDED AMENDED			23d. Date of delivery
	certificate be executed conding physician and use as the burial - transi	an/M	Con 144 I I I I I I I I I I I I I I I I I I	Fetal death 3 Ectopic pregna	incy	Month Day Year
	Box 687 e death certific the attending ed for use as the	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		
		P P		he underlying cause given in Part I.		cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
	S, P. uires the signed of be de	ed b			24a. Was an	24b. Were autopsy findings available
	Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. The standard of the respect of the respect of the respect of the respect of the rule of the rul	Completed by			autopsy	
	Rec The The ficate	5	25. Was case referred to medical	26.Place of Death (Check	1 ✓ Yes 2 only one)	No 1 Yes 2 No
	/ital sician sician is certi	e Be	examiner? Hospital: 1 Inpatient 2 V ER/Outpa	tient 3 DOA Other Nursin	ng Home 5 Re	esidence 6 Other:
	sion of Vital Attending Physician: r death. ector: After this certif by the funeral director.	ř	27 Manner of Death 128a Date of Injury 28b. Time	e of Injury 28c. Injury at Work?	28d. Describe how	w injury occurred
	Sion Vittendi death.	catio	Natural 5 Pending Investigation Production P	1:30 pm	1	eet and Number or Rural Route Number, City
	Divis	Certification:	3 Suicide 6 X Could not be determined (Specify) found	in car	or Town, Star National	eet and Number or Rural Route Number, City te) 6600 Baltimore Pike, Catonsville, M
	Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the			occurred at the time, date and place, and	d due to the cause(s) and manner as stated. In place, and due to the cause(s)
	To the within To the	Medical	one) 2 Medical Examiner: On the basis of examination and/or inve- and manner stated.	29c. License number		29d. Date signed (Month, Day, Year)
		2	29b. Signature and title of certifier	O.C.M.E.	i	October 22, 2009
	Λ		30. Name and address of person who completed cause of death (Item 23a)			
	•)		Patricia Aronica-Pollak MD. Assistant Medical Examine	er 111 Penn Street, Baltimo	re, MD 21201	
	Reg	State		J		
		-				

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 9 109 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 19,2009 OCT. **Physician** Year Annabelle Neoma Mowen 9:24p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 12203 Brookfield Ave. 4b. City, Town, or Location of Death Examiner Hagerstown, Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

7 7 Yrs Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ F 219-44-2652 73 Yrs. Rouzerville Director 6-23-1936 Usual Residence of Decedent PA 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-1 show th and Mental Hygiene. 17 ie marked other than "natural", or Itame 23a or 28a-1 shov traumatic event, the Madical Examinat must be notified at MD Washington Hagerstown 1 ☐ Yes 2√2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12203 Brookfield Ave 21740 U.S.A. death Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married _{Specify}.white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry financial institute Elementary/Secondary (0-12) College (1-4or 5+) courier 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Earl Jacob Whitmore Goldie Neoma Swope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 le any Injury or other trau Lester Earl Mowen 12203 Brookfield Ave. Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition . 23, 20c. Location - City or Town, State Oct 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hagerstown, MD Broadfording Memorial 2009 Gardens and Address of Facility
Donald Edwin Thompson Funeral Home, Inc 21. Signature of Junery Service Life 23a. Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximately a such as cardiac or respiratory arrest. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 year (0160 Luncer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) After thi 27. Manner-of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the massiver death.

Within 24 hours after death.

To the Funerel Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10.22.09 4166 Mulomal MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical Comos Hagerstown MO 21742 MCor Michael mack 11110 31. Date filed (Month, Day, Year) 2009 32. Pégistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 35118

		1- For State Registrar			Certific	ate of	Death				R	eg. No.	2	UU:	, ,	J I
Physicia	an/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year Month Day Year														
edical Exami	ner	John Robe		iller							October 1	8, 20	09		1204 hrs	
		4a. Facility Name (if not institute Washington County F		number)		4	b. City, Tow Hagerst		ocation of	Death			County of Vashingt			
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last bir	thday)	If Under 1	Year	If Under	_	8. Date of Bi	rth (MM/				
Director		214-28-5538	1 X M 2 F		86	Yrs.	Months	Days	Hours	Min.	Nov 2	9,		Foreign Count	West Vir	ginia
'n		Usual Residence of Decedent 10a. State 10b. County	,	I10c	. City, Town	or Locatio	on.							T 10	d. Inside Ci	tv Limits
ow an			ington		Boonst		ĮII.								Yes 2	. 1
rylanc a-f sh	ctor	10e. Street and Number	TIIECOII		JOULIST	JOLO	10f. Zip Co	ode				10g. Citi	izen of Wha	it Country	?	
b, MD 21215-0036 and 2 should be filted within 72 hours after death with the Maryland testift and Mental Hygiene. The m 27 is marked other than "natural", or items 23a or 28a-f show any traumatic event, the Medical Examiner must be notified at once.	Director	17875 Bakersvil	lle Road				21	713			İ		U.S.	Α.		
with t ns 23a se not		11. Marital Status	12. Was D	ecedent Eve	r in U.S.	13. Was	Decedent	of Hispa	anic Origi	n? (Spe	cify Yes or N)-	14. Race -	America	n Indian, Bla	ck,
r death wi or items must be	Funeral	1 Never Married 2 X	1 Yes	Forces?	No		es, specify (Puerto R	tican, etc.)	-1	White,		-i + -	
safter rall, o	by F		ivorced If Yes, Give Y or Dates:				Yes 2 X			and of one	-l. dono	lach.	Specify:		nite	
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21215-0036 unid be filed within 7 Mental Hygiene. marked other than c event, the Medica	Con	17. Father's Name (First, Middle	e, Last)					18	3. Mother's	Name (First, Middle,	Maider	Surname)	<u> </u>		
121 I be fi ental I arked	Be			Miller			45/45-E-I		Emn		Reb			Brin		
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and 2 ealth 3		20a. Method of Disposition	r / wile				ition (Name				Date		Location -			
E = E = F			on 3 Removal	from State		atory or oth		0207		10/1	23/200		hovno	huno	More	zland.
Baltimo permit. Page Department or Important: injury or oth		4 Donation 5 Other 5 21. Signature of Funeral Service			ric. V		Cemet				z5/200 t-Stau					
Ba Perm Imp	1	A Danos	ulellas	7							Pike :					
Physician		23a. Part I. Enter the disease, of failure, List only one caus		caused the	death. Do r	not enter th	ne mode of	dying, s	uch as ca	rdiac or	respiratory a	rest, sh	ock, or hea	rt	Approximate Between O	
/Medical caminer		Immediate Cause (Final diseas	Charle ini	iries com	plicating	rupture	d left ver	tricle							Dea	th
		or condition resulting in death)	Due to (or as b. Atherosci			ular Disa	ease									
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as			alai Dio	0000									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	C	2 000000116	ance of):			_						-		
uted id ansit		events resulting in death) Last	d.	a conseque	sirec orj.											
rds, P.O. Box 68760, requires that the death certificate be executed been signed by the attending physician and rould be detached for use as the burial - transit	/Medical	UNPENDED	AMENDE)												
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Box 68: death certiff the attending	Physiciar	past 12 months?		gnant at time	e of death		her (Specif		Lotopic	program	icy		Wichter	50	,	
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Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification: To	3 Suicide 6 Co	ould not be 28e. P	ace of Injury				office bu	ilding, et	c.	28f. Location or Town, Sharpsburg	(Street State)	and Number	er or Rura	I Route Nun	nber, City
Divi		29a. Certifier	Physician: To the t	(y) Major				ime dat	e and nia					as stated		
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check only one) 2 Medical Ex	caminer: On the bas and manne	is of examina	ation and/or	r investiga	tion, in my	pinion,	death oc	curred at	the time, da	e and p	lace, and d	ue to the	cause(s)	
To To	Me	29b. Signature and title of certif		stateu.		-	29c.	License	number			29d	. Date signe	ed (Mont	h, Day,Year,	
		anal	-					O.C.N	1.E.			Oc	tober 19	, 2009		
		30. Name and address of person					Stroot D	altim -	ro MAD	21204						
	106		ssistant Medica	Registrar's		·	Street, Ba	arunno	IG, IVID	21201						
Regis	tate trar	31. Date filed (Month) (Party)	1 2009	Genewa	h	be	wed									
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Martin Ronald Μ. 23:57 P M 2009 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly Prince George's Hospital Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours t**√** M 2□ F 578-52-1568 71 Yrs. Director June 18, 1938 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercises. 10h County 10c. City, Town or Location 10d. Inside City Limits 1√2 Yes 2 □ No Director Maryland Prince George's Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20743 United States 7313 Central Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Specify. Black 3 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Mechanic 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Martin Ginny Hall ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7313 Central Avenue Capitol Heights, MD 20743 Helen T. Martin - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park Oct 17, 2009 Landover, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. ure of Functal Service Sig -4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Coronary Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Status Post Myocardial Infarction The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical Hypertension as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) the a 9 Unknown à s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 2 🗆 No 1 □ Yes 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 1∐Yes 2XNo Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day, Year) Injury 1 XNatural 5 Pending 1 □Yes 2 □ No investigation filled in by the fi 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifie 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mappler stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 5051 October 14, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Drive Cheverly, MD 20785 Ali Pourmand, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 n 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For State Registrar	otato o. m	<i>y</i>	Ce	rtifica	te of L	Death	···o·ital (1	Reg. N	2009	35120
	Dhysisia	n/	1. Decedent's Name (First, Middle,	Last)						2. Date of [Death		3. Time of Death
	Physicia Medic		Russell Donald N							Octob	er 1	8, 2009	1350 ™
	Examin	er	4a. Facility Name (if not institution,		# 1	(00			Location of Dea	th	1	c. County of Death	
	Funeral		6100 Westchester 5. Social Security Number			ast birthday)		lege		8. Date of E		rince Geo	orge's
	Director		220-58-5794	1 🖾 M 2 🗆 F	56	Yrs.	Month		Hours Min		Sav, Year)	953 Wash	ington, DC
	nd thow at	or	Usual Residence of Decedent 10a. State 10b. County	4	10c. Cit	y, Town or Lo	ocation					Ī	10d. Inside City Limits
	taryla 3a-f s tified	ect	Maryland Prince	George's	Co1	lege P	ark						1 ☐ Yes 2 🛣 No
	the N	I Dir	10e. Street and Number					Zip Code	-		10g. C	Citizen of What Cou	untry?
	n with	Funeral Director	6100 Westchester	: Park Drive	, #1	609	20	740	_			U.S	S.A.
	death r item ner n		11. Marital Status	12. Was Decedent E Armed Forces?		3. 13.	Was Dec If Yes, sp	edent of Hi ecify Cuba	ispanic Origin? (5 n, Mexican, Puer	Specify Yes or Note to Rican, etc.)	0-	14. Race - Amer Black, White	
36	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🖾 Divorced	ed 1 🖾 Yes 2 🗌 If Yes, Give Year or Dates.]		072	1 🗌 Yes	2 🛣 No	Specify:			Crosifu.	nite
ğ	hours natura lical E	Completed	15. Decedent	's Education	19/2-1	16a. Dece		sual Occup			16b.	Kind of Business I	
215	iin 72 ie. han " e Mec	omp	(Specify only highes Elementary/Seconday (0-12)	College (1-4 or 5	i+)	(Give life. D	kind of w OO NOT u	rork done o ise retired)	luring most of wo	orking	Ť		,
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anc	ntal Fred of	To B	17. Father's Name (First, Middle, La Russell Donald M	,					18. Mother's Na Wanda M	ame <i>(First, Middl</i> ildred 1		*	
2	should be file and Mental I is marked or raumatic eve		19a. Informant's Name/Relationship			19b Maili	na Addre	es (Stroot :				or Town, State, Zip	Code)
Š	2 ± 2 ± 2		Lawrence A. Mask			1			Colton's				5555)
e,	of Heal		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation	2 Domewal from State	20b. P	Place of Dispo emetery, crea	osition (N	ame of	e)	Date	20c.	Location - City or 1	Town, State
Ĕ	Page ment tant: I		4 Donation 5 Other (Sp			ropolit			y 10/	19/2009	A16	exandria,	Virginia
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of the Important: If ite any injury or of once.		21. Signature of Funeral Service Lio	ensee	ok	/			ss of Facility Ineral H	ome, PA			nore Avenue e, MD 20781
H		П	23a. Part 1. Enter the disease, or o shock, or heart failure. List on										Approximate
1	Physician Medical	l	Immediate Cause (Final disease or condition resulting in death)	_ a. Widely	Meta		c To	ngue	Cancer				Interval Between Onset and Death Months
_	Examiner			Due to (or as a	a consequ	ience ot):							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequ	uence of):							
	outed nd ransit	Examiner	Cause (Disease or linjury that initiated events	c									
	e exe		resulting in death) Last	Due to (or as a	a consequ	ience of):							
3760	ificate be executed ng physician and as the burial-transit	Medical		d									
Ó	pertification noting use as	_	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of								23d. Date of deliv	verv
Box	requires that the death cert been signed by the attendin should be detached for use	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 4 Pregnant at 9 Unknown			Other		У		.	Month	Day Year
д. О	at the d by the etach		g Unknown Part II. Other significant condition		ut not res	ulting in the I	ınderlyin	n cause div	en in Part I	220 Did	tabassa	una contributa to t	the cause of death?
λ. J.	requires that the been signed by the should be detach	d by	, and the control of grant of the control of the co	to down by	u	and an area	and only mi	g oddoo giv					obably 4 🗆 Unknown
ğ	been shoulk	lete	-							24a. Wa			opsy findings available
ပ္တ	ne law e has i	Completed								aut per	opsy formed?	prior to co death?	ompletion of cause of
一一	an: Th tificat tor, pa		25. Was case referred to medical	1				26. Pla	ace of Death (Che		2 🗷 N	No! 1 ∐ Yes	2 No
Ĭ	nysici nis cer direc	To E	examiner? 1 Yes 2 No	Hospital:	ent 2 🗆	ER/Outpatie	nt 3 🗆	DOA Othe	er: 4 🗆 Nursing	Home 5 🖾 Re	sidence	6 Other (Specif	(y)
0	ing Pl	ate:	27. Manner of Death1 ☒ Natural5 ☐ Pending	28a. Date of injur (Month, Day		28b. Time of injury	f	28c. Injury work	?	28d. Describe	how inju	ry occurred	-
Ö	ttend death stor: / the f	Certificate:	2 Accident Investiga 3 Suicide 6 Could no	ot be	nı - At bo	mo form etr	M		Yes 2 No	004	/D44	- / N h D	of Devide Misselve
Division of Vital Records,	tal or A rs after al Direct ed in by		4 Homicide determin	28e. Place of Inju building, etc	. (Specify,)	eet, facto	ory, office		City or To		nd Number or Rura e)	ai Houte Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 s	Medical	(Check 2 Medical Ex	Physician: To the best of raminer: On the basis of ex Nurse Practioner: To the basis	camination	and/or inves	tigation, i	n my opinio	n, death occurred	at the time, date	and plac	e, and due to the ca	ause(s) and manner stated
	To the within To the comp	2	29b. Signature and title of certifier	O I	best of frig	Kilowiedge,		9c. License		lace, and due to		ate signed (Month,	
			DANIAL)	Aux	us			D2143	8		1	20 Old	09
١	1408		30. Name and address of person w										
			Michael J. LaPen	ta, M.D., 44	45 De	efense	Hig	hway,	Annapo	Lis, MD	2140)1	
	Stat	е	31. Date filed (Month Day, Year OCT 2 0 20	Jy Dengua	p.	Har							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 18, Day 2009 6:20 A Dolores Marshall С. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Pineview Nursing & Rehab. Center Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, You August 16, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Months Days Hours Min. 1 ☐ M 2XXF Ohio 281-26-5702 78 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2x No Prince George's Temple Hills Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8601 Temple Hills Road #24 20748 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates 1 □Yes 🏋 📆 No Specify: Specify: White ¾ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Barrick Matilda Eunick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Russell Ave. St. Catharines, Ontario, Canada L2R1V3 Bernice McQuay/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Vet. Cemetery 4 ☐ Donation 10/22/2009 Cheltenham, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature of uneral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland Approximate Interval Between Onset and Death 23a. Pert 1. Enter the disease, or complication what caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one care on each line. Immediate Cause (Final Metastatic Lung (ancer disease or condition resulting in death) > 3 monly Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsaled or jury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🗱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 X No 1 ☐ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

12th

Directo

Funeral

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Completed

Be

2

Funeral

Director

: if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examination must be notified at

and Mental Hygiene.

permit. Pages 1 and 2 to Department of Health at Important; if item 27 is any injury or other traus Pages 1 and 2

2 should be f

filed within 72 hours after

Baltimore, Maryland 21215-0036

Examine physician and is the burial-tran Physician/Medical attending p signed by the a ð Completed been s has e 2 s page ; After this certificate funeral director, pag Be Certification: To death. within 24 hours after death

To the Funeral Director:
completely filled in by the

The law requires that the death certificate be executed

Box 68760,

P.0.

of Vital Records.

Division

Hospital or Attending Physician:

To the

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2x1X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1. Natural

5 Pending investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

txcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10050545 GODSWILL

State Registrar

Medical

31. Date filed (Month, Day

NEW

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

3

			1 - State Registrar	State of Maryla	ınd / Depa <i>Cer</i>	artment of Heal <i>rtificate of Dea</i>	th and Meni ath	tal Hygie Reg.	2009	35122
	Physic /Medi		1. Decedent's Name (First, Middle, La Gladys	M.	MacDo	ougall	l N	ate of Death	Dav Year	3. Time of Death 9:00 A M
	Examir Funeral		4a. Facility Name (If not institution, given Pineview Nursing 5. Social Security Number 6. Social Security Number	& Rehab. Center	s. last birthday)	4b. City, Town, or Locat Clinton	tion of Death	ate of Birth Month, Day, You	4c. County of Death	rge's
	Director work		216-54-8075 Usual Residence of Decedent 10a. State 10b. County		Yrs.		Aug	gust 5, 1		ngland 10d. Inside City Limits
	with the Ma a or 28a-f s	Funeral Director	Maryland Prince Ger 10e. Street and Number 6616 Livingston Roa		Oxon Hill	10f. Zip Code	F	10g.	Citizen of What Cou	1 □Yes ¾¾ No untry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-f show any Injury or other traumatic event, its Madical Evarings must be positifed an once.	2	11. Marital Status 1 Never Married 2 Married 3 Maridwed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	lf	2074. Vas Decedent of Hispanic Yes, specify Cuban, Mex □Yes 2⊠No Spe		res or No- o, etc.)	USA 14. Race - Ameri Black, White, Specify: White	, etc.
Baltimore, Maryland 21215-0036	filed within 72 ho Hygiene. Ither than "natur ent, Ire Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12th	ducation ide completed) College (1-4or 5+)	(Give I	ent's Usual Occupation kind of work done during in NOT use retired)	most of working	16b	. Kind of Business/Ir	
yland	should be file and Mental Hy s marked oth umatic event	To Be (17. Father's Name (First, Middle, Last, John Rimme	er		M	other's Name <i>(Firs</i> ary Rut	ter		
e, Mar	1 and 2 sh Health and em 27 Is π		19a. Informant's Name/Relationship (Daniel MacDougall / 20a. Method of Disposition	Son	6614	g Address (Street and Nu Livingston Road		, Maryla	nd 20745	5
Itimor	permit. Pages: Department of I Important: If ite any Injury or o		↑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of Signature Funeral Service Liger	y) F	t. Lincol	ition (Name of atory or other place) Cemetery Name and Address of Fi	10/21/200	9 Br	entwood, Mar	cvland
Ba	perr Dep Imp any		23a. Pauf . Enter the disease, or com shock, or heart failure. List only	lat	616	Name and Address of Fa O Oxon Hill Ro or the mode of dying, such	oad Oxon Hi	11, Mary	s Funeral HU land 20745	
done.	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conse	statio	o oran				Onset and Death
68760,	ificate be executed g physician and is the burial-transit	edical Examiner	Sequentially list conditions, and heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C						
O. Box		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of deliv	very Day Year
ords, P.	w requires that s been signed b should be deta	ρ	Part II. Other significant conditions o	ontributing to death but not re	sulting in the und	derlying cause given in Pa	art I. 2	3e. Did tobacc	co use contribute to t	the cause of death?
al Reco		Completed						4a. Was an autopsy performed′ □Yes 2 □	prior to co death?	opsy findings available ompletion of cause of
Division of Vital Records,	₹	ion: To Be	27. Manner of Death 13 Natural 5 ☐ Pending	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day, Year)	ER/Outpatient 28b. Time of Injury	3 DOA Other: 4 2 28c. Injury at Work?	28d. D		6 Other (Special	fy)
Division	al or Attendi s after death. Il Director: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At houlding, etc. (Special	nome, farm, stree	M 1 □Yes 2	28f. Lo	cation (Street ty or Town, St	and Number or Rura ate)	al Route Number,
		edical	one)	ysician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, death ation and/or inve	estigation, in my opinion,	death occurred at t	he time, date a	and place, and due to	o the cause(s)
)	V With		29b. Signature and title of certifier	godosi,	دس	29c. License numb		29d. (Date signed (Month,	Day, Year)
2	4		30. Name and address of person who of 7513 NEW 31. Date filed (Month, Day, Year)	completed cause of death (Itel	m 23a) (Type, Pi	int) GODSW IEME T	-AKOMA	PA	CODI	20912
I	Stat Registra	٠,	OCT 2 0 2009 X	32. Registrar's Sign	arks					

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 35123 Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month MURPHY MARGARET CECELIA 12:44 AM Physician 2009 KTOBER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HARLES LAPLATA ENTER IVISTA Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Davs Hours 1 □ M 2 🔀 F JAN.6,1937 WASH., D.C. Director 215-64-5672 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Eventing must be mittlind at 1 XYes 2 □ No Director MD CHARLES LA PLATA 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20646 S. Α. ONE MAGNOLIA DRIVE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 X No Specify þ 3 ☐ Widowed 4 Divorced WHITE Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) NURSING HOME 12 CTIVITY DEPARTMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOHN O. CLEMENTS EDNA MALINDA HERBERT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 29991 RICHARD CIRCLE MECHANICSVILLE, MD20659 MARGARET M. HODGE/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition OCTOBER M3Burial 2 ☐ Cremation 3 ☐ Removal from State TRINITY MEM.GRDNS. 30,2009 | WALDORF, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses RAYMOND FUNL.SERVICE, P.A. and Bet WASHINGTON AVE., LA PLATA, MD 20646 M00641 5635 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mod, of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** / /Medical Due to (or as a conseque ce of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a con sequence of) Due to (c Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): ed by the attending physician detached for use as the burial Physician/Medical If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use. 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be (Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA patient Certification: To After this 28d. Describe how injury occurred funeral 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Injury 1 v atural 5 Pending investigation 1 □Yes 2 □No within 24 hours after death.

To the Funeral Director: A 2 Accident filled in by the 6 ☐ Cofuld not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Medical 29a. Certifier completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHON 32 State 10 Registrar

DHMH 17 Rev 1/2001

1 - For State Regi 1. Decede

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, The institute Instituted at any injury or other traumatic event, The institute Institute at any once.

To Be Completed by Funeral Director

2

State Registrar eccedent's Name (First, Middle, Las	(t)		Certifica	ate of L	Death		Re 2. Date of Death		009	3. Time 0	2 of Death
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☐ Widowed 4 ♣Divorced	If Yes, Give Year or Dates:	-	1 □Yes	2 No	Specify:			Sp	ecity: V	VHITE	
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Immedia disease resulting Physician /Medical **Examiner** Sequent if any, lec cause. E Cause (I that initia resulting Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit IF FEMA 23b. Was in th Part II. O 25. Was exar 1 27. Mani 1 2 ... 3 | 4 | 29a. Ce 29b. Signature and title of 30. Name and address of person processing the completed cause of death (Item, 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature State 19 OCT 2009 Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Frances Neuben October 9,2009 1:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Rockville
eriyear if Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
0 ct. 2, 19: Casey House Montgomery
9. Birthplace (State or Foreign Country) If Under 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F Months 73 Yrs 578-48-5121 1936 Washington, DC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heath and Mental Hygiene.
ant; If item 27 is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, It is Medical Examinar must but a diffied at 1XYes 2□No Director Maryland | Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20002 Frederick Road, #33 Funeral 20876 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White If Yes, Give Year or Dates: ð 3₺ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Medical Society <u> Answering Service Operator</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert E. Wade Ford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Neuben/Daughter 3612 Singleton Terrace; Frederick, MD 21704 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important; If ite
any Injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 10/20/09 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line.

Immediate cause (Final disease or condition resulting in death)

a. Metastatic Pancreatic Cancer 1040 Rockville Pike; Rockville, MD 20852 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the buriai-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 9 X Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Hypertension, Diabetes Mellitus, Hypothyroidism Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sh autopsy performed? 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) \square Hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 K Natural ours after death. neral Director; Aff filled in by the fur 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number · KOWATCHOU, October 9, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, M.D. 6001 Muncaster Mill Road; Rockville, MD 20855

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 2 0 2009

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10 - 09 - 2009**Physician** ROALD E. OLSEN 3:29 PM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY 8. Date of Birth (Month, Day, Year) 03-27-30 If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 538 28 2519 WASHINGTON 79 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at DC WASHINGTON 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1201 VARNUM STREET N.E. 20017 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify. Specify: þ 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) CAPITOL HILL HOSPITAL Elementary/Secondary (0-12) College (1-4or 5+) Hygiene, CUSTODIAN 12th s 1 and 2 should be filed wi f Health and Mental Hygier Item 27 is marked other th other traumatic event, Ins 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည EMIL OLSEN SELMA ANDERSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) FIORELLO S. VICENCIO/ P.O.A. 319 8th STREET N.E. WASHINGTON, DC 20002 permit. Pages 1 and Department of Health Important: If item 27 any injury or other troonce. Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RIVERDALE PARK 10-21-2009 RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JOHN T. WASHINGTON, BCL 20017 21. Signature of funeral Service Linna e Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Imme late Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the use as IE FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy ò in the past 12 months? Month Year signed by the a 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performed certificate 2 No 1 ☐ Yes 2 💢 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signa 29d. Date signed (Month, Day, Year) on who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Lisa Jill Prigal Unknown October 04, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12317 Pueblo Road Montgomery Gaithersburg If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Funeral Days 1 □ M 2 🖺 F Director New York 226-88-8962 45 May 16, 1964 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any linjury or other traumatic event, the Medical Event in a must be nother once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No Directo Maryland Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20878 U.S.A. 12317 Pueblo Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 🗷 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 A No \$ Specify: 3 Widowed 4 Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Secretary Lockheed Martin 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Arthur Prigal Fern Klein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14008 Burning Bush Lane, Wheaton, Maryland 20906 Arthur Prigal - Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/19/2009 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center Edmonston Crossing Shopping Center, Rockville, MD 20852 23a. Part 1. Enfe the dises e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due 1 (or an consequence of): Onset and Death **Physician** /Medical Due (or and consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 No 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one)

I or Attending Physician: The law requires that the death certificate be executed after death.
Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760 filled in by within 24 hours a

Baltimore, Maryland 21215-0036

Certification: To Medical

examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Natural 5 Pending 581 investigation Unt 1 ☐ Yes 2 No りさす 3,2009 2 Accident 3 Suicide 4 ☐ Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route City or Town, State) determined State)[23/7] WOITHNIE OVY 29a, Certifier

mp 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

2 Dung 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pa, K

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State Registrar mu omE

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		For State Registr <i>a</i> r		State of	Marylan	id / Dep	oartme e <i>rtifica</i>	nt of h	lealth and I	Mental H	ygier Reg. M	1e ₂ 0	09	35	128
Physicia /Medic		1. Decedent's Nam YORK	e (First, Middle, Las PANG)						2. Date of D Month OCT •		2009	Year		of Death
Examine		Casey	If not institution, give House					Rock	r Location of Death			Ic. County of MONT	GOME		
Funeral Director		5. Social Security N 504-25-5	466	x 7. ZM 2□F	Age (In yrs. 43	last birthda Yrs.	y) If Und Months	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of E (Month, I Aug.	Sirth Day, Yea 31,	1966	Coun	lace (Star try) hina	te or Foreign
f show	or	Usual Residence of 10a. State	10b. County Montgome	v	10c. Cit	ty, Town or Boyds				· -			1		City Limits
with the Na or 28a-	I Director	10e. Street and Nu		-				ip Code	41		10g. (Citizen of W		try?	
al",o	by Funeral	11. Marital Status	ied 21 Married	12. Was Decedor Armed Force 1 Yes 2 If Yes, Give Year or Date	es? <mark>⊠</mark> No	.S. 13	3. Was Dec If Yes, sp 1 □ Yes		dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)	cify Yes or No- lican, etc.) 14. Race - Black, ' Specify:			American Indian, White, etc. Asian	
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Pages 1 and ent of Heal out: If item 2 ry or other		20a. Method of Dis	-	Removal from St	apre []	Place of Dis cemetery, o		ame of other plac	ce)	Date 24/09	20c.	Location -	-		
permit, i Departm Importa any Inju once.			uneral Service Licen	-/-/-	weed		22. Name	and Addre	ss of Facility Si shington	JOWDEN					• Amelia e
Physician		23a. Part 1. Enter to shock, or hea Immediate Cause disease or condition		ne cause on ead	used the deat ch line.			ode of dyi	ng, such as cardiad	or respiratory	arrest,			Approxir Interval Onset a	nate Between nd Death
/Medical Examiner		resulting in death)		u	r as a conseq		- L								
ecuted transit	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated events	S	c		consequence of):									
icate be executed physician and the burial-transit	ca	resulting in death)	Last	Due to (or	r as a conseq	isequence of):					(6				The state of the s
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quires that the de on signed by the a uld be detached f	ρ	Part II. Other significant conditions continuously to dealin but not resulting in the underlying cause given in rail rich.									ntribute to the cause of death				
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certifice ector, p	Be	25. Was case reference examiner?		Hospital:	-			T O#	er.	ath (Check onl	(Check only one)			spice	
ending Physician; bath. or: After this certifica he funeral director, p	ation: To	1 ☐ Yes 2X 27. Manner of Dea 1 X Natural 2 ☐ Accident		28a. Date of (Month	patient 2 Injury , <i>Day, Year)</i>	ER/Outpat 28b. Time Injury	e of	28c. Inju Wor	rv at	lome 5 ☐ Re 28d. Describ				_{5y)} 110	22100

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fune

Medical Certification

3 ☐ Suicide

29a. Certifier

4 Homicide

State Registrar

determined

6 ☐ Could not be

29c. License number D63748

TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6001 Muncaster Mill Rd. Rockville, MD 20850 Jocelyne Kouatchou, M.D.

31. Date filed (Month, Day, Year)

OCT 2 0 2009

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			1 - For State Registrar	State of M	aryland / [Оера	artmei	nt of H	lealth Death	and M	lental Hy	giene2	009	35129
	Physici /Medi		1. Decedent's Name (First, Middle, L. Pearl J. Petrosk:	<u></u>							2. Date of De Month Octobe	r 20,	2009	3. Time of Death 6:30 A M
4	Examir	ner	4a. Facility Name (If not institution, gas 898 Accident-Frie	endsville	Rđ.		4b. City, Town, or Location of Death Accident 4c. County of D Garrett					rrett		
b	Funeral Director		184-20-4615	Sex 7. A(1 □ M 2 🔀 F	ge (In yrs. last bir 82		Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day, Year) March 11, 1927 Po			place (State or Foreign intry) nnsylvania
	e Maryland la-f show	Director	Usual Residence of Decedent		10c. City, Town		cation							10d. Inside City Limits 1 □Yes 2 X No
	h with the 23a or 28 st be no		10e. Street and Number 898 Accident-Frie	endsville 1	ndsville Rd.			10f. Zip Code 21520				10g. Citizer	n of What Cou	intry?
980	J within 72 hours after death with the Maryland glene. If than "natural", or items 23a or 28a-f show the Modes! Evanirar must be neithed at the Modes!	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:				Vas Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rica			ecify Yes or No Rican, etc.)	y Yes or No- an, etc.) 14. Race - A Black, W Specify:		
21215-0036	within ene. than "	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation rade completed) College (1-4or	5+)	(Give life. I	dent's Usual Occupation kind of work done during most of work DO NOT use retired)			st of worki	ing		of Business/I	ndustry
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-	nd 2 sho alth and 27 is m r traum		19a. Informant's Name/Relationship Mary Rosser/Daugh	,			U	•			al Route Numb			
Baltimore,	permit. Pages 1 al Department of Hec Important: If item any injury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		20b. Place of cemeter All Sa						31, 20		tion - City or 1	
Balt	permit, Departi Imports any inji		21. Signature of Funeral Service Lice	ensee EWMa		- 1					man Fur tsville		Homes, 21536	P.A.
	Physician /Medical Examiner		23a, Part 1. Enter the disease, or cor shock, or hear ailure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each l	ne.	16		1		-47	or respiratory a			Approximate Interval Between Onset and Death
	te be executed ystcian and ie burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence									
8760,	icate be ey physician the burial	ca		d.										
O. Box 68	death certifi e attending ed for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (specify) 9 Unknown 9 Unknown 9 Unknown 1 Live birth 2 Fetal death 5 Other (specify) 9 Unknown 9 Unknown 9 Unknown 1 Live birth 2 Fetal death 5 Other (specify) 1 Live birth 2 Fetal death 5 Other (specify) 1 Live birth 2 Fetal death 5 Other (specify) 1 Live birth 2 Fetal death 5 Other (specify) 1 Live birth 2 Fetal death 5 Other (specify) 1 Live birth 2 Fetal death 5 Other (specify) 1 Live birth 2 Fetal death 5 Other (specify) 1 Live birth 2 Fetal death 5 Other (specify) 1 Live birth 2 Fetal death 5 Other (specify) 1 Live birth 2 Fetal death 5 Other (specify) 1 Live birth 2 Live bir									230	d. Date of deli	very Day Year	
ords, P.	w requires that the s been signed by th should be detache	۵	Part II. Other significant conditions	contributing to death t	out not resulting in	n the ui	nderlying	cause giv	en in Part I	l.		tobacco use Yes 2 🛃	/	the cause of death?
of Vital Records,	The la ate has page 2	Completed									24a. Was auto perfe 1 🗆 Yes		prior to death?	topsy findings available completion of cause of 2 No
VII.	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				OA Oth		e of Deatl	h (Check only	one)		
	ding Phys n. After this funeral dir	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da		itpatier Time of njury		28c. Injui Wor	ry at		me 5 Res 28d. Describe			eify)
Division	i di di di	Certification:	3 Suicide 6 Could not determined	28e. Place of In	jury - At home, fa tc. <i>(Specify)</i>	rm, str	eet, factor			-	28f. Location City or To	(Street and I wn, State)	Number or Ru	ral Route Number,
	o the Hospital ithin 24 hours s the Funeral I ompletely filled	Medical (hysician: To the best miner: On the basis and manners	of examination ar									
	of the property of the propert	M	29b. Signature and title of certifier				29	c. Licens	se number			29d. Date s	signed (Month	, Day, Year)

Division of Vital Records, P.O. Box 68760, To the vithin To the comple

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ken Duczynski, m.D. 311 Nth Fourth

31. Date filed (Month, Day, Year)

OCT 23 2009

32. Registrar's Signature

			For State Registrar		State of Ma	aryland / D	epa <i>Cer</i>	rtment of H <i>tificate of L</i>	lealth and D <i>eath</i>	Mental Hy	giene Reg. No	2009	35130
	Division		1. Decedent's Name (Firs	st, Middle, Last)						2. Date of De			3. Time of Death
	Physici /Medic		Verna	Marie	e Pau	gh				Octobe		*	09 7:44A M
	Examin	er	4a. Facility Name (If not in	nstitution, give s	treet and number)			4b. City, Town, or	Location of Dea	ith	40	. County of De	eath
	Farment		Garrett C 5. Social Security Number			ospita (In yrs. last birti		Oakla If Under 1 Year	and If Under 24 Hr	s. 8. Date of Bir	rth	Garre	した birthplace (State or Foreign
	Funeral Director	١.	218-62-598	4.07	M 2]X] F		rs.	Months Days	Hours Mir		av Year	2	Country) RYLAND
	pu ,		Usual Residence of Dece	dent									
	arylar shov	7	10a. State 10b.	County		10c. City, Town	or Loc	ation					10d. Inside City Limits 1 □Yes 2√□No
	the M	Director	MD 10e. Street and Number	Garret	t	Fr	ier	ndsville	e		10a Ci	tizen of What 0	**
	3a or		680 Teet	a Doná	1			21531		Ì	Ü	U.S.A	
	death	Funeral	11. Marital Status		Was Decedent E Armed Forces?	ver in U.S.	13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Specify Yes or No		14. Race - An	nerican Indian,
0	72 hours after death with the Maryland natural", or items 23a or 28a-f show Stell Exemples must be profilled at		1 Never Married 2		1 ☐Yes 2X N	lo		res, specify Cubai □Yes 2√∑No	n, mexican, Pue Specify:	rto Hican, etc.)		Black, Wh Specify:	ite, etc.
- - - -	hours tural"	ed by	3 ☐ Widowed 4 🔀 🗅		Year or Dates:	160		ent's Usual Occupa			165 1		White
	iin 72 n "na n solge	Completed	(Specify onl	Decedent's Educ ly highest grade	completed)		(Give k	ind of work done d O NOT use retired,	luring most of wo	orking	100. 1	and or busines	s/muusiry
7	filed within Hygiene. other than "ent, Ire Me	Com	Elementary/Secondary 12	(0-12)	College (1-4or 5-		urs	se's Aio	de		N	ursing	g Home
2	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Ms	Be	17. Father's Name (First,	Middle, Last)					18. Mother's Na	me (First, Middle	, Maider	Surname)	
<u> </u>	should and Men s marke umatic	2	(Unknown						(Unkno				
2	d 2 sh Ith an 17 Is r traur	1	19a. Informant's Name/R		,			Address (Street a					
<u>ה</u>	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Memtal Hygiene at the filen 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experimental Level of the defined at	. 17	Rebecca 20a. Method of Disposition	n				tion (Name of atory or other place		Date Date		ocation - City of	
allillo	Page:		1 ☐ Burial 2 反 Crer 4 ☐ Donation 5 ☐ C	mation 3 Re	emoval from State			atory or other place side Cre	i	23/09	Son	nerset	Dλ
<u></u>	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra	13	21. Signature of Funeral		e 1 1	1 COunt		Name and Addres					Homes P.A.
۵	9 9 E 8 9		Kich	1 Mcd	VI				Second	St., 0	akl		MD 21550
		S 16	23a. Part 1. Enter the dise shock, or heart failu	ease, or complic ire. List only one	ations that caused cause on each line	the death. Do n	ot ente	r the mode of dying	g, such as cardia	ac or respiratory a	ırrest,		Approximate Interval Between Onset and Death
100	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a.	_Aca	tk 1	K	rox/	Faile	WE			days
7	Examiner				Due to (or as a	consequence of		c vasu	ulan d	SCRUCE			1.84115
		Jer	Sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	s, b.	Due to (or as a	consequence of	- 12	· vajo	LLCIO!	TERMIN			9.0/-
19	ocutec nd transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1 c.	Midle	RIRS							46405
5	be exectan a	E	resulting in death) Last		Due to (or as a	consequence of	f):						
00	ficate be executed g physician and s the burial-transit	edical		d.	,								
5	eath certificate be executed attending physician and for use as the burial-transit	n/M	IF FEMALE: 23b. Was decedent pregn	nant 23	c. If yes, outcome of							23d. Date of d	lelivery
	ed for	Physician/M	in the past 12 month 1 □Yes 2 ☑No		1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnancy Other (specify)				Month	Day Year
ָ :	d by ti	Phy	9 Unknown				Al	1	- In Donald	non Didd			As the server of death?
, S	uires that the de	py	Part II. Other significant of	CHA 1	we crisid	checiX	ine und	enying cause give	n in Part I.				to the cause of death? Probably 4 Unknown
3	w requir s been s should	Completed	Markla vaxio	777	an Bu	>1 A	7	J. Care A	NW.	24a. Was			
ָב ב	isician: The law s certificate has b lirector, page 2 s	dmc	W. Tal	1100	9/20200	10, 17	- K- K-	- SUNCA) "/	auto	psy ormed?~	prior to	
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>	hysic his ce I direc	일	examiner? 1 ☐ Yes 2 ☑ No	Ho	ospital: 1 Inpatier	nt 2 🗆 ER/Out	patient	Otho		Home 5 ☐ Resi		6 □Other (Sp	pecify)
= .	ding Physician: The Ih. After this certificate ha funeral director, page		27. Manner of Death 1 ☑ Natural 5 ☑	Pending	28a. Date of Injur (Month, Day		me of jury	28c. Injury Work		28d. Describe	how inju	ry occurred	
	death death stor: / the f	icati	2 ☐ Accident 3 ☐ Suicide 6 ☐	investigation Could not be	28e. Place of Injur	ov - At home farr	m etro		′es 2□No	29f Location (Ctroot	nd Alumbas or	Pural Pouta Number
2	after after Direct	Certification:	4 Homicide	determined	building, etc.	(Specify)	ii, succ	st, lactory, office		City or To			Rural Route Number,
-	To the Hospital or Attending Physician: The law requires that the death certiful 24 hours after deforation. Within 24 hours all prector: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier 1 C	ertifying Physi	cian: To the best o er: On the basis of	f my knowledge,	death	occurred at the tim	ne, date and place	ce, and due to the	cause(s	s) and manner	as stated.
	the H hin 24 the Fi	Medical	one)		and manner stat	ed.				uned at the time,			
	0 4 ¥ 0	<	29b. Signature and title of	certifier	1,0			29c. License	number	11	29d. Da	ite signed (Moi	nth, Day, Year)
		r	30. Name and address of	person who are	nnleted cause of do	ath (Item 22a) /7	Type D	rint)	0618	0 /		(0)	2117
		3	Ken Buczyr				-		te #1.	Oakland.	MD	21550	7
	Sta	_	31. Date filed (Month, Day	v, Year)	32. Registra		4						
	Registra	ar	OCT	2 3 2009	1 Desire	JA. 1	pa	Kad					

State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** OCTOBER 4:10 A^M 2009 **ESTELLE** PROCTOR MARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Months Days Hours 578-00-0089 85 MARCH 11 1924 MARYLAND Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State show t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Modical Examinat must be notified at 1X Yes 2 □ No Director PRINCE GEORGE'S MD LANHAM 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 8916 FAIRVIEW AVENUE 20706 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 14. Race - American Indian, 11. Marital Status Black White etc. within 72 hours after 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: BLACK 2 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within all Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 7TH HOUSEWIFE PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEON I. PROCTOR SUZANNA BUTLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) TONDALEYA SOFIDIYA/DGT 8916 FATRVIEW AVENUE LANHAM, MARYLAND 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter 3 Removal from State 1 ☐ Burial 2 ☐ Cremation RESURRECTION CEMETERY 10/23/2009 CLINTON, MARYLAND 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service T. C. 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PNEUMONIA **Physician** disease or condition resulting in death) i /Medical Due to (or as a consequence of): Examiner HYPERCAPAIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine g physician and as the burial-transit law requires that the death certificate be executed PULMONARY HYPERTENSON Due to (or as a consequence of): Box 68760. Physician/Medical for use as IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for o ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown icate has been si END STAGE RENAL DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an RAPID ATRIAL FIBRILLATION autopsy performed? certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Division or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director; filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OCTOBER 19, 2009 D0056108 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND 20910 WRIGHT M.D MARY 31. Date filed State Registrar

DHMH 17 Rev 1/2001

		1	For State Registrar	State of Maryla	nd / Depa Cer	tificate of De	aith and iv	rientai Hygi Re	ene 2009	35132		
	Physicia	n/	1. Decedent's Name (First, Middle, Las $Julia M.$	Parker				2. Date of Death Month Oct.	2 ^{Day} 200	3. Time of Death 9 1845 M		
	Medic Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or Lo			4c. County of Dea	th		
			5511 Mountvil 5. Social Security Number 6. So		last histoday)	Adamst	OWN f Under 24 Hrs.	8. Date of Birth		erick thplace (State or Foreign		
	Funeral Director			ex	Yrs.		Hours Min.	(Month, Day,) 09/13/	1955 Wa	shingtonDC		
	yland -f show ed at	ctor	10a. State 10b. County		ity, Town or Loc			-		10d. Inside City Limits 1 ☐ Yes 2 🕅 No		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Dire	MD Frede	rick	Auam	stown 10f. Zip Code		10	Og. Citizen of What C	Citizen of What Country?		
		Funeral Director	5511 Mountvill			2171			United S			
21215-0036	rs after deat ıral", or item Examiner r	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Year or Dates.		Vas Decedent of Hispa FYes, specify Cuban, I		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi			
2-0	72 hour	Completed	15. Decedent's E (Specify only highest gra		(Give I	lent's Usual Occupation kind of work done during NOT use retired)	on ing most of work	ing	16b. Kind of Business	Industry		
212	vithin jiene.		Elementary/Seconday (0-12)	College (1-4 or 5+)		scal ass	istant		educatio	n		
pu	ed other	To Be	17. Father's Name (First, Middle, Last)	D la		18		e (First, Middle, Mi ra Ann				
ıryla	ould be nd Men marke matic		Robert Stewart 19a. Informant's Name/Relationship (7)		19b Mailir	ng Address (Street and				ip Code)		
Baltimore, Maryland	nd 2 sh salth ar n 27 is er trau		Harvey Moore/h			1 Mountv		d, Adam	stown, N	ID 21710		
ore	ge 1 ar nt of He : If iten or oth		20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from State	cemetery, cren	sition (Name of natory or other place)			20c. Location - City o			
ltim	nit. Pag artmen ortant: injury injury		4 ☐ Donation 5 ☐ Other (Special Service License)		ate of	Heaven Name and Address of	Cem 10 of Facility Ke	/30/09 enev &	Silver S Basford	Spring,MD FH		
Ba	permir Depar Impor any in		Deepulve 1	MO1:	222 1	06 E. Ch	urch S	t., Fre	der <u>ick,</u>	ID 21701		
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused the de ne cause on each line.	ath. Do not ente	er the mode of dying, s	such as cardiac	or respiratory arres	st,	Approximate Interval Between Oaset and Death		
F	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conse		nan				- 6 NOVING		
and the same	Examiner	Ĺ	Sequentially list conditions,	b	7							
	sit 3d	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury	Due to (or as a consequence of):								
	icate be executed physician and s the burial-transit	Exal	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					-		
09	ite be e hysicia he bur	edical	•	d								
Box 68760	ath certifi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown			23d. Date of d Month	elivery Day Year					
P.O.	requires that the der been signed by the a should be detached	by Ph	Part II. Other significant conditions of	ontributing to death but not n	esulting in the ι	ınderlying cause given	n in Part I.	23e. Did tob	acco use contribute	to the cause of death?		
ds,	quires ten signant	ted b						1 20	s 2 No 3 No	Probably 4 🗌 Unknown		
COL	law rei has be je 2 sho	Completed						24a. Was an autops perform	y prior to	utopsy findings available completion of cause of		
- Re	sician: The certificate rector, pag		25. Was case referred to medical		-	26. Place	e of Death (Chec	1 Yes 3	No 1□Y			
Vita	Physicia this cert ral direct	To Be	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	Other:			nce 6 Other (Spe	ecify)		
οt	iing Pr		27. Manner of Death Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work?	nt es 2 □ No	28d. Describe how	w injury occurred			
Division of Vital Records,	To the Hospital or Attending Physician: The k within 24 hours after death. To the Funeral Director: After this certificate h completed filled in by the funeral director, page	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not to 4 Homicide determined	28e. Place of Injury - At			es 2 🗆 NO	28f. Location (Str.	eet and Number or F	ural Route Number,		
<u>≥</u>	urs afte ral Din			building, etc. (Spec								
	Hosp 24 ho Fune leted fi	Medical	Check 2 Medical Exam	sician: To the best of my kno iner: On the basis of examinat se Practioner: To the best of	ion and/or inves	tigation, in my opinion,	death occurred a	at the time, date and	d place, and due to the	e cause(s) and manner stated.		
	To the within To the comp	2	29b. Signature and title of certifier	W.		29c. License n	umbor	21	Od Data signed (Mor	oth Day Vearl		
	V01		30. Name and address of person who	completed cause of death (lite	em 23a) (Type, I	Print) RING	Potru	c Put	20% OL	27/2009 U7/120332		
	Sta		31. Date filed (Month, Day, Year)	32. Penistrar's Sign	nature	,		1 1'				
DUA	Registr		NOV 0 2 2	119 Am	13. 16	artist						

DHMH 17 Rev 7/2009

* The state of the

State Registrar DHMH 17 Rev 1/2001 OCME 2006 111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

Jack Titus MD.

31. Date filed (Month,

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

	Physician
	/Medical
	Examiner
_	

Funeral Director 28a-f show event, the Medical Examiner must be notified at with ö 23a 72 hours after death items ; ō "natural"

Physician /Medical Examiner

3altimore, Maryland 21215-0036

and use as the burial-tran attending physician for use as the buria or Attending Physician: The law requires that the death certificate be ed by the a detached f s been signed be should be deta certificate has page 2 After this

P.O.

Division of Vital Records,

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2009 4:50 P M October Christine B. Robitzek 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Wilson Health Care Center Montgomery 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12/02/1919 Gaithersburg Social Security Number Birthplace (State or Foreign Country) 1 ☐ M 2 🗓 F 264-40-1171 Tennessee Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director 1XIYes 21 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 Russell Avenue 20877 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 XNo Specify. Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ran in Jujury or other traumatic event, in Medangone. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arland Hugh Smith Alice Elizabeth Baldwin ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gretchen Rezash (Trustee) 6264 Oak Leaf Lane Fayetteville, PA. 17222 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State October 0 4 ☐ Donation 5 ☐ Other (Specify) 2009 Alexandria, Virginia 21. Signature of Funeral Service Lice 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD. 20877 23a Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line e death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Acutecereb disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 🖬 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🖪 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy later perforn 1 ☐ Yes 2 No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04115

death.

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GAITHERSBURG,

Physician /Medical Examiner

Funeral Director

with the Maryland 28a-f show ir than "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Madical Examina

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

or Attending Physician: The law requires that the death certificate be executed after death. P.O. Box 68760, Records, Division of Vital Director: After the in by the funeral

24 hours a within 2 To the I

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5:30 A M October 2009 12, Lawrence Ravitz 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Months 1 X M 2 □ F 545-14-9708 Sept. 91 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State District of 1XYes 2 ☐ No Director DC Columbia Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20008 Funeral 4701 Connecticut Avenue, NW Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: Specify: White <u></u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Writer/Film Producer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Isaac Ravitz Jeanette Canner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4701 Connecticut Ave. NW Washington, DC 20008 Eva Ravitz/Spouse 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/19/09 Brentwood, Maryland Ft. Lincoln Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville Pike; Rockville, MD 20852 23a. Part 1. E rie the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in art failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Corse (Final Intraventricular Hemorrhage Days disease or condition resulting in death) b Cerebrovascular Accident - hemorrhagic Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Tyes 2 No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Hypertension, status post cerebrovascular accident, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Type 2 Diabetes Mellitus autopsy performed? Yes 2 2 No 1 ☐Yes 2 🗷 No 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certifier D 0065485 suparich Rom un 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road; Silver Spring, MD 20910 Barbara Supanich, M.D. 2. Registrar's Signature 31. Date filed (Month, Day, Year) OCT 2 0 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 35136

Physician edical Examiner Ronald Franklin Reeves Ronald Franklin Reeves Ronald Franklin Reeves As. Facility Name (if not institution, give street and number) 4a. County of Death County 4a. County of Death County 4a. County of Death County 4a. County of Death County 4a. County of Death County 4a. County of Death County 4a. County of Death County 4a. County of Death County 4a. County of Death County 4a. County of Death County 4a. County of Death County 4a. County of Death County 4a. County	Fime of Death 2248 hrs
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Funeral Director Second Security Number S	
Social Security Number 213 - 36 - 5773 1	
Director 213-36-5773 12	ace (State or
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Truck Driver Specify: White, etc. White	Indian Black
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2 2 3 3 3 3 4 1 1 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cases(s) and manner of the best of my knowledge, death occurred at the time, date and place, and due to the cases(s) and manner of the best of my knowledge, death occurred at the time, date and place, and due to the cases(s) and manner of the best of my knowledge, death occurred at the time, date and place, and due to the cases(s) and manner of the best of my knowledge, death occurred at the time, date and place, and due to the cases(s) and manner of the best of my knowledge, death occurred at the time, date and place, and due to the cases(s) and manner of the best of my knowledge, death occurred at the time, date and place, and due to the cases(s) and manner of the best of my knowledge, death occurred at the time, date and place, and due to the cases(s) and manner of the best of my knowledge, death occurred at the time, date and place, and due to the cases(s) and manner of the best of my knowledge, death occurred at the time, date and place, and due to the cases(s) and manner of the best of my knowledge, death occurred at the time, date and place, and due to the cases(s) and manner of the best of my knowledge, death occurred at the time, date and place, and the best of my knowledge, death occurred at the time, date and place, and the best of my knowledge, death occurred at the time, date and place, and the best of my knowledge, death occurred at the time, date and place, and the best of my knowledge, death occurred at the time, date and place, and the best of my knowledge, death occurred at the time, date and place, and the best of my knowledge, death occurred at the time, date and place, and the best of my knowledge, death occurred at the time, date and the best of my knowledge, death occurred at the time, date and the best of my knowledge, death occurred at the time, date and the best of my knowledge, death occurred at the time, date and the best of my knowledge, death occurred at	cause(s)
and manner stated. 29d. Date signed (Monte) 29d. Date signed (Monte)	th, Day, Year)
O.C.M.E. OCME October 15, 2009	
30. Name and address of person who completed caus to death (Item 23a)	
Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar OCT 2 0 2009	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

Dhyeioi	an	For State Registrar 1. Decedent's Name (First, Middle, Last)		ificate of De	2. Date of De	Day Year	3. Time of Death
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Examin	er	The Johns Hopkins Hospital		Baltimore C		io. County of Cour	
			yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. 8. Date of Bi	rth 9. Bir	thplace (State or Forei
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8		Usual Residence of Decedent 10a. State 10b. County 10c	c. City, Town or Loca	ation			10d. Inside City Lin
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r 28a- notifie	Director	10e. Street and Number		10f. Zip-Code		10g. Citizen of What Co	untry?
23a o st be		14600 Gibbons Church Road		20613		United St	ates
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ed ot	Be	Wilbert Rankin, Sr.			Johinine Ell	lis	
mark	ပူ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing	g Address (Street ar	d Number or Rural Route Num		Zip Code)
27 is		Diane Rankin - Wife	14600) Gibbons	Church Road Br	randywine, N	D 20613
item othe		20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispos	sition (Name of atory or other place)	Date	20c. Location - City or	Town, State
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Department or read and western registers are then 23a or 28a-f show montant; if then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	A 9LAT		of Facility Stewart 1 ng Road, NE Was		
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d by the attending p detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pl 1 □ Live birth 2 □	Fetal death 3 🗌			23d. Date of de Month	elivery Day Year
the at	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time 9 Unknown	or death 5	Other (specify)		-	
ed by detac		Part II. Other significant conditions contributing to death but no	ot resulting in the u	nderlying cause give	n in Part I. 23e. Dic	tobacco use contribute	to the cause of death
been signed should be d	d by				1	Yes 2 10 3 F	robably 4 🗌 Unkn
s been 2 shou	Completed		•		24a. Wa	opsy prior to	utopsy findings avail completion of cause
ge ge	E				per 1 \(\tau \) Yes	formed? death?	s 2 No
	Be C	25. Was case referred to medical examiner?			26. Place of Death (Check only	one)	
o o	မှ	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient	2 ER/Outpatient		4 Nursing Home 5 Ne		ecify)
leatn. or: After thi the funeral	ü	27. Manner of Death 28a. Date of Injury 1 □-Natural 5 □ Pending (Month, Day Yea	28b. Time of Injury	Work?		e how injury occurred	
tor: A	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury -	At home, farm, stre			(Street and Number or I	Rural Route Number,
arrer dear Director: I in by the	Certification:	4 Homicide determined building, etc. (S)			City or To	own, State)	
within 24 hours after de To the Funeral Director completely filled in by th		29a. Certifier (check only one) 1 • Certifying Physician: To the best of my check only and manner stated	amination and/or inv	occurred at the time restigation, in my op	e, date and place, and due to the inion, death occurred at the time	ne cause(s) and manner and date and place, and d	as stated. ue to the cause(s)
thin 2 the l	Medical	one) and manner stated 29b. Signature and title of certifier		29c. License	number	29d. Date signed (Mor	ith, Day, Year)
≥ २ %		A		RES	-000	October 12	,2000
		30. Name and address of per on the completed cause of death	h (Item 23a) (Type,			1	
4		31. Date filed (Month, Day, Year) OCT 2 0 2009 Server 32. Registrar's S			600 North W	olfe St, Baltim	ore, MD, 21

			For State Registrar	State of Mar	yland / Dep <i>Ce</i>	artment <i>rtificate</i>	of He	alth a eath	nd Me	ental Hyg	iene _{eg. No.} 20	09	35	38		
	Physici	an	Decedent's Name (First, Middle, Last) Haydee		Rigor				1	Date of Deat Month	h Dav	Year	3. Time of	Death M		
A.	/Medic Examin		4a. Facility Name (If not institution, give s	own, or Lo	ocation of		October :	4c. County	of Death	8:50 P						
1	xamii		Ft. Washington Hospit	al		Ft. Was	shingt	on		Prince George's			e's			
	Funeral Director		210-94-9374) 0 1	(In yrs. last birthday,	If Under 1 Months I		f Under 2 Hours	Min.	8. Date of Birth (Month, Day OV 14,	9. Birthplace (State pourty) 1928 Philippine			r Foreign		
	land Dw		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or Lo	ocation						1	0d. Inside Cit	y Limits		
	Mary a-f sho	tor	Maryland Charles		Waldorf								1 ☐ Yes	2 XX		
	ith the	Director	10e. Street and Number			10f. Zip C				1		itizen of What Country?				
	s 23a nust k		10659 Ashford Circle	10 W D t F			20603 USA s Decedent of Hispanic Origin? (Specify Yes or Noes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Ra Bla					a Amorio	an Indian			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the M dical Examiner must be notified at once.	ted by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3XX Widowed 4 □ Divorced	12. Was Decedent Ev. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	er in U.S. 13.	was Deceder If Yes, specify 1 ☐ Yes 2		Mexican, Specify:	in? (Spec , Puerto R	lican, etc.)		ce - Americ ck, White, y: Fil				
2-00	72 hou natura Ilcai E		15. Decedent's Educ (Specify only highest grade	eation	16a. Dece	dent's Usual (Occupation design	on	of working		16b. Kind of B	usiness/Ind	dustry			
Baltimore, Maryland 21215-0036	d within 7 giene. r than "r th M d	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) years	ſ	kind of work DO NOT use ty Inspe		ing most	OF WORKING		Reagan N	Vat'1.	Airport			
pu	be filed Ital Hyg Id othe event,	Be	17. Father's Name (First, Middle, Last)				18			(First, Middle, N		ne)				
ryla	thould id Mer marke matic	မ	Edilberto Jallores 19a. Informant's Name/Relationship (Type)	ne Print)	19h Maili	na Address (S	Street and		arcela r or Bural	Aset		State 7in	Code			
, Ma	and 2 s aith an 27 is er trau		Elma J. Rigoroso-Rill							, Marylai			Code)			
ore,	ges 1 a t of He If item or othe		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ R	emoval from &tate	20b. Place of Dispo cemetery, cre	osition (Name matory or oth	of er place)	1 1	Da	'	20c. Location	-				
Iţi m	it. Pag rtment rtant: njury o		4 □ Donation 5 □ Other (Specify)	/	Resurrecti				10/22/		Clinton	2.00,000				
Ba	Depa Impo any i	21. Signatur of Funeral Service Ligensee 22. Name and Addr 6160 Oxon H							1 Oxon		aryland	20745				
			23a. Part . Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition													
	Physician /Medical	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):														
	Examiner		Sequentially list conditions													
	ted nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence of):											
oʻ	death certificate be executed e attending physician and of for use as the buriat-transit	Exar	that initiated events cresulting in death) Last	Due to (or as a	consequence of):											
8760,	ate be hysicia the bu	lical	€ d													
Ó	death certifica attending pl	/Mec	IF FEMALE:						22d Date of delivery			- 1				
Box	death	Physician/Medical Examiner	in the past 12 months?	3c. If yes, outcome pf 1□Live birth 2 4□Pregnant at tir 9□Unknown	Fetal death 3	⊒Ectopic preg ⊒ Other <i>(spec</i>					23d. Date of delivery Month Day Year			'ear		
P. 0	hat the d by the	Phys	9 ☐ Unknown Part II. Other significant conditions con		not reculting in the L	endorlying cou	uso simon	in Dort I		220 Did tob	pacco use con	tributo to th	o sausa of d	nath?		
or Vital Records,	The law requires that the drate has been signed by the page 2 should be detached	d by	- Atoli	11.1.1		maenymy cau	ise giveri	III Fall I.		_			ably 4′ ⊠ U			
CO	238	Completed	diabetes	· '						24a. Was a	n 24b.	Were auto	psy findings a	available		
<u> </u>	: The	Com	hyperte.							autops perforr 1 Yes 2	ned?	death?		use or		
Zii.	s ician: Th certificate rector, pag	Be	25. Was case referred o medical examiner?	ospital:			Othor			Check only on						
0	ding Physician: The n. After this certificate he funeral director, page	n: 70	27. Manner of Death	1 ∐ Inpatient 28a. Date of Injury	2 ER/Outpatie		c. Injury a	4 🗆 Mur		e 5 🗆 Reside 3d. Describe ho			y)			
Sior	eath. or: After the funer	atio	1 Matural 5 Pending 2 Accident investigation	(Month, Day Y	/ear) Injury	М		s 2□N	lo							
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc. (- At home, farm, st (Specify)	reet, factory, o	office		28	Bf. Location (St. City or Town	reet and Numb n, State)	ber or Rura	l Route Num	ber,		
_	To the Hospital or Attending Physician: whith 24 hours after deals after deals. To the Funeral Director: After this certifical completely filled in by the funeral director,		29a. Certifier Certifying Phys	ician: To the best of	my knowledge, deat	h occurred at	the time,	date and	d place, ar	nd due to the ca	ause(s) and m	anner as s	tated.			
	To the Ho within 24 h To the Fu completely	ledical	(Check only 2 Medical Examir one)	er: On the basis of each and manner state	xamination and/or ir d.				h occurre)		
	Mith To T	Σ	29b. Signature and title of certifier	MO		29c. L	License n	umber	18-) 2	9d. Date signe	d (Month,	Day, Year)			
	2		30. Name and address of person who con		th (Item 23a) (Type	Print)		J > 6	, /	/	10/1	1/0	7			
L			Tuan-Anh V	V, MO	Signature	711 4	-141	155/	en 1	Ped f	Cort i	Vish	ing pen,	m _D		
	Sta Registr		OCT 2 0 2009	32. Registrar's	parke											

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	oraro or many	Ce	rtificate of	Death	1	Reg. No. 2	109	35	139
			1. Decedent's Name (First, Middle, La	ast)				2. Date of Dea	ath Day	Year	3. Time of	Death
н	Physici /Medi		Rosa	Mercedes	Silva			October			5:56	A. M
are of	Examir		4a. Facility Name (If not institution, given	ve street and number)		4b. City, Town,	or Location of Death	h	4c. County	of Death		
			11 Tulip Drive				ersburg		Mor	ntgom	ery	
	Funeral				yrs, last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h y, Year)	9. Birth	place (State o	r Foreign
	Director		090-38-0030	1□M 23€ F	65 Yrs.				, 1943	Nica	ragua	
	and *		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ncation					10d. Inside Ci	ty Limits
	Sho	5			,				1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			*
	the N	ect	Maryland Montgo 10e. Street and Number	mery	Gaither	sburg 10f. Zip Code			10g. Citizen of	What Cou	ntry?	
	with a or	ā				,	~ ~		Ü			
	ns 2%	Funeral Director	11 Tulip Drive	12. Was Decedent Ever	in U.S. 13.	Was Decedent of		pecify Yes or No-	Unite		can Indian,	
က	riter o		1 Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 🔀 No			Hispanic Origin? (S ban, Mexican, Puert	o Rican, etc.)	Bla	ck, White,	etc.	
03	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 XXYes 2 ☐ No	Specify: Nic	araguan	Specif	y: His	panic	
21215-0036	72 hours after death with the Maryland hatural", or items 23a or 28a-f show dical Extention must be Lofffled at	Completed	15. Decedent's E	ducation		edent's Usual Occu			16b. Kind of B			
2	2 should be filed within 7 n and Mental Hygiene. is marked other than "n raumatic event, It a Mad	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)	King				
2	ed wi	ပ္ပ		2	Sch	ool Bus	Attendant			_	tation	
pu	be fill d oth even	Be	17. Father's Name (First, Middle, Last	1)			18. Mother's Nan	ne (First, Middle,	Maiden Surnar	ne)		
Maryland	ould Men arke	은	Daniel	Robleto				Petror		arcen		
Nar	2 sh n and is n		19a. Informant's Name/Relationship		Ī	•	et and Number or Ru					
6,	1 and 2 Health: tem 27 i		Jorge G. Silva/Sp				ve, Gaith	ersburg,	Maryla 20c. Location			
Baltimore,	ges in of h		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	_ Hemovai from State		osition (Name of matory or other pla	i			•		
ŧΪ	t. Pa rtmer rtant:		4 ☐ Donation 5 ☐ Other (Speci		Metropol:	itan Cren	natory 10	/22/09	Alexand	ria,	Virgin	iia
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examiner must be notified at once.		Signature of Funeral Service Lice	7000	/-		ress of Facility DeV					
			One Post State the disease of the	The state of the s			er Park I			rg, M		
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	death. Do not en	iter the mode or dy	ring, such as cardiac	or respiratory ai	rest,		Approximate Interval Bet Onset and I	ween
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Amyotroph	ic Later	al Scler	osis					
-	Examiner			Due to (or as a co	nsequence of):							
		-e	Sequentially list conditions, if any leading to immediate	b. Due to (or as a co	nsequence of):							
	uted d insit	i E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
Ć,	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):							
68760,	te be ysicia e bur	g		d								
	rtifica ng ph as th	Medical										
Вох	eath ce attendir for use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		☐ Ectopic pregnar	ncv			ate of deliv	,	
	e dea	sici	in the past 12 months? 1 ☐ Yes 2 🖾 No	4 Pregnant at tim		Other (specify)			M	onth	Day	Year
P.0	that the deneed by the detached to	Physician/	9 Unknown					T				
	res th igner	ρ	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	inderlying cause g	iven in Part I.		obacco use con			
of Vital Records,	w requires been signed should be	Completed						1 🗆 1	res 2 XNo	3 Pro	bably 4 L	Jnknown
ec	law nasb e 2 st	ם						24a. Was autop	sv	prior to co	opsy findings ompletion of c	available ause of
=		ပ္ပ						perfo	rmed? 2 X No	death? 1 🗆 Yes	2 □No	
/ita	sician: certific rector,	Be	25. Was case referred to medical examiner?	11				ath (Check only o	ne)			
of \	Physician: this certific al director, p	၉	1 Yes 2 XNo		2 ER/Outpatie	IN 3 DOA		fome 5 🛭 Resid			ify)	
		ion:	27. Manner of Death 1	28a. Date of Injury (Month, Day, Ye	ar) 28b. Time o	Wo		28d. Describe h	now injury occur	red		
Sic	e ri at u	cat	2 ☐ Accident investigatio	00	A4 b		∃Yes 2 □No	005 1 11			10 00	
Division	I or Atter after dear Director: I in by the	Certification:	4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At nome, farm, st Specify)	reet, factory, office		City or Tov	Street and Numi vn, State)	ber or Hura	ai Houte Num	ber,
	Hospital 4 hours 2 Funeral tely filled		29a. Certifier 1 XCertifying P	hysician: To the best of m	v knowledge dea	th occurred at the	time date and place	e and due to the	cause(s) and m	nanner as	stated	
	24 h	Medical		miner: On the basis of exa	amination and/or i	nvestigation, in my	opinion, death occu	urred at the time,	date and place,	and due t	to the cause(s)
	To the Hospital or Atter within 24 hours after dea To the Funeral Directo completely filled in by th	Me	29b. Signature and title of certifier	//,		29c. Licer	nse number		29d. Date signe	ed (Month,	Day, Year)	
	17/		1/2/18	2 W/d		000	5387	2	10/1	9/2	109	
	1		30. Name and address of person who	completed cause of death	(Item 23a) (Type,		0007	~	10/1	100	1	
			Nicholas Maragak				et Baltin	nore, MD	. 21287			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	40						
	Registr	ar	OCT 2 0 200	19 Centur	p. gran	Acres 1						

DHMH 17 Rev 1/2001

	1 - State Registrar			Cei	rtificate of L	Death			_{3. No.} 20	UD	35140		
ian cal	1. Decedent's Name (First, Middle Robert Peter Sc	chmit						ate of Death lonth Lober 17	7, Day 2009	Year	3. Time of Death 7:05 p M		
ner	4a. Facility Name (If not institutio		4b. City, Town, or		Death		4c. County of Death						
	Montgomery Hospic				Rocks	ville If Under 24	(Hro La D	and the second	Montgomery				
	5. Social Security Number 359–16–1472	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. la:	st birthday) Yrs.	Months Days		Min. 8. D	ate of Birth Month, Day, ril 29,	Year) 1926	9. Birthpi Count Illin			
	Usual Residence of Decedent 10a. State 10b. County	,	10c. City.	Town or Lo	cation					10	Od. Inside City Limits		
Director	Maryland	Montgomer	у	Silve	er Spring					1 ☐ Yes 2 ☐ No			
	10e. Street and Number 13608 Mills Aver	nue			10f. Zip Code 20904	4		109	g. Citizen of V USA	vnat Count	uyr		
Funeral	11. Marital Status	12. Was De	cedent Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origi	in? (Specify \	res or No-		e - America			
þ	1 ☐ Never Married 2 🔼 Mar 3 ☐ Widowed 4 ☐ Divorced	1111-	2 □ No		1 ☐ Yes 2 ☐ XNo	Specify:	ruelto nical	Specify: Wi					
leted		nt's Education est grade complete	a)	16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most o	of working	10	16b. Kind of Business/Industry				
Completed	Elementary/Secondary (0-12)	College 4	(1-4or 5+)	mo. i	Salespersor			I	Electronics Components				
Be	17. Father's Name (First, Middle, Last) John Peter Schmit 18. Mother's Name (First, Middle, Mai Margaret Becker												
2	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2												
	Joanne Schmit/Wif	e											
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		m State I		sition (Name of matory or other plac aven Cemeter	, u	Date ctober 2 2009	22,	oc. Location - Silver S	•	wn, State Maryland		
	21. Signature of Funeral Service	Licensee	2r		Tancis Addre					D 2090	01		
	23a. Part 1. Enter the disease, o shock, or heart failure. Lis	or complications that t only one cause or	t caused the death. each line.								Approximate Interval Between Onset and Death		
	Immediate Cause (Final disease or condition resulting in death) a. Esophageal Cancer Due to (or as a consequence of):												
	Due to (or as a consequence ot):												
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.												
al Exar	that initiated events resulting in death) Last	c	o (or as a conseque):									
dica		d											
Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Liv	outcome of pregnan re birth 2 Fetal egnant at time of de	death 3[☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _			_	23d. Date of delivery Month Day Ye				
	Part II. Other significant condit	ions contributing to	death but not resul	ting in the u	nderlying cause giv	en in Part I.		23e. Did tob	acco use con	tribute to th	ne cause of death?		
ted b	Hypertension —						_	1 🗆 Yes	s 2 □ No	3☐ Prob	oably 4 🛣 Unknown		
Completed by								24a. Was an autopsy perform	,	Were auto prior to con death?	psy findings available mpletion of cause of		
	05 184	-1						perform 1 □ Yes 2		1 🗆 Yes	2 □No		
Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ► No	Hospital:	☐ Inpatient 2 ☐ E	P/Outpatio	nt 3 🗆 DOA Oth	or:		eck only one	nce 6 🖰 Otl	ner (Canaif	Hospice		
ion: To	27. Manner of Death 72 Natural 5 ☐ Pendi	28a. Da		28b. Time o Injury	f 28c. Injur World	y at k?	28d.		w injury occur	-	y) <u>-</u> -		
Certification:	3 Suicide 6 Could	minod 200. Pla	nce of Injury - At hor ilding, etc. (Specify,	ne, farm, sti		Yes 2□N	28f. I	ocation (Str. City or Town,	eet and Num State)	ber or Rura	al Route Number,		
edical Cer			the best of my know										
1 ±	one)		anner stated.		gamen, minny (, 2, 0001			p	'			
Jec	29b. Signature and title of certifier J. Keuchcheu 29c. License number D63748 29d. Date signed (Month, October 1									Day Year)			
Med	29b. Signature and title of certific J - I U U U U	tcheu	L				3	29					

State Registrar 31. Date filed (Month, Day, Year) 0CT 2 0 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyne Kouatchou, MD 1355 Piccard Drive, Rockville, MD 20850 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 17, 2009 October 12:06pM Arkadiy Sadkov /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Country)
August 2, 1931 Russia 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 X M 2 □ F 219-85-3382 78 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2 XNo Director Rockville Maryland | Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20852 1439 Templeton Place United States Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Engineering Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nina Zhukova ဂ္ Ivan Sadkov 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1439 Templeton Place, Rockville, MD 20852 Vladimir Sadkov (Son) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 10/19/09 Alexandria, Virginia 22 Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Fuperal Service Licensee 23a. Part 1. Enter n. e diseas and complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedial Common (Final disease or condition resulting in death) rous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed

Funeral

Director

and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show raumatic event, it is Medical Expriser into the inclined at

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked oth any Injury or other traumatic event

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

9

burial-transit attending physician for use as the buria

eral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached within 24 hours after death To the Funeral Director:

Records.

Vital

Hospital

Sad Division

Part II. Other significant conditions	contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacco use cor	ntribute to the cause of death? 3 Probably 4 Unknown
			24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical		26. Place of D	eath (Check only one)	
examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ☐ ER/Outp	atient 3 DOA Other: 4 Nursing	Home 5 Residence 6 ☐ Of	ther (Specify)
27. Manner of Death 1	n .	ne of ury M 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury occu	ırred
3 ☐ Suicide 6 ☐ Could not be determined		n, street, factory, office	28f. Location (Street and Num City or Town, State)	nber or Rural Route Number,

29b. Signature

(Check only

29a. Certifier

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6430 Rockledge Drive, Bethesda, MD 20817 Amirali Nader,

31. Date filed (Month, Day, Year) State Registrar

OCT 20 2009

State of Maryland / Department of Health and Mental Hygiene 35142 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 18, 2009 5:20 A M Margaret Jane Snodgrass /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Somerford Place Frederick If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Min. Hours 1 □ M 2 🗓 F May 29, 1928 West Virginia 81 Director 220-20-0814 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21702 USA 2100A Whittier Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after c nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or iter 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 📉 No altimore, Maryland 21215-0036 Specify: Specify: White þ 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Social Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Earl Snodgrass Teresa Ann Brady ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lisa Margaret Moore/daughter P.O. Box 516 Frederick, MD 21705 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or conce. 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State Final Journey Crematory 10/19/09 Woodbine, MD 5 ☐ Other (Specify) 4 Donation 21. Signatural Funeral Ser Going Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician emen TIG disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. certificate has been signed by the rector, page 2 should be detached 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 ☐No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural n 24 hours after death.

e Funeral Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D60417 MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johnson Dr. Frederick Mb 21702

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Owen Clinton Stamp, Sr. October 15, 2009 30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis of LaPlata LaPlata Charles If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F Director 579-05-0672 93 July 26. 1916 | Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location show be filed within 72 hours after death with the Marylantal Hygiene.

ed other than "natural", or items 23a or 28a-f showevent, the Medical Eventing must be notified at 1 ☐ Yes 2X No Director Maryland Prince Georges Clinton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 10109 White Avenue 20735 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💢 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status 1 ☐ Yes 2 🕅 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. ð Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n and Mental Hygie 11th. Cabinet Maker Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be McGruder Stamp ပ Bessie Barrett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any Injury or other trau Owen C. Stamp, Jr./ Son 10109 White Avenue, Clinton, Maryland, 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Barnabas Cemetery Oct. 19, 2009 Temple Hills, MD. 21. Sign, tu e of Funeral Servi e License 22. Name and Address of Facility Huntt Funeral Home Mh 3035 Old Washington Rd. Waldorf, Maryland, 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 24 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FEMIEN T Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) physician and the burial-tran that initiated even certificate be execu resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical the ası attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. signed by the at be detached f □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 3 Probably 4 Unknown 1 🗌 Yes 2 🔀 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy certificate 1 □ Yes 2 No 2 🗆 No 1 ☐ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No this. 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Will Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After thi funeral (28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:

completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 065 Name and address of person who completed cause of death (Item 23a) (Type, Rrint) 31. Date filed (Month, Day, Year, egistrar's Signature 19 2009 OCT Registrar

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 7:30 Anna Szwec АМ 2009 October 0 15. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Hours Vear) Days Min. 1 □ M 2 🛛 F Months 579-48-7167 86 Director May 18, 1923 Ukraine Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, tre McJicil Eva , it wit must be rediffed a 1 X Yes 2 □ No Director Maryland Prince George's Hvattsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20781 4112 Queensbury Road, #2 Ukrainian Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married □Yes 2 No Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: þ White 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) District Government Housekeeper permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any lipiry or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unav. Unav. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) Maria Szwec / Daughter 4112 Queensbury Road, #2, Hyattsville, MD 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Metropolitan Crematory 10/24/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Constance Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Non **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 Al No certificate 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Deat 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hospital or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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Registrar

State

DHMH 17 Rev 1/2001

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		For _ State		State of	Marylar	nd / Dep	partment of I	Health and	Mental Hy		009	35145
		State Registrar 1. Decedent's Name (First, M.)	iddle, La:	st)			er inicate or	Deain	2. Date of De			3. Time of Death
Physicia /Medic		Ronald	Havw	rood S	immons	s, Jr.			Oct -b	er 7,2	Year OOS	0027 M
Examine		4a. Facility Name (If not instit					4b. City, Town, o	or Location of Deat	h		y of Death	
,'		8476 Imperia 5. Social Security Number	1 Dr		Age (In ure	last birthda	Laurel		8. Date of Bi			eorge's place (State or Foreign
Funeral Director		578-98-5491		M 2□F	45	Yrs.	Months Days	Hours Min.		lay, Year)	Cour	nington, DC
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f shov	ō		,	George's		Laure	_					1 K Yes 2 No
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er dea items	Funeral	11. Marital Status		12. Was Decede	es?	J.S. 13	 Was Decedent of I If Yes, specify Cub 	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or N to Rican, etc.)	o- 14. Ra Bla	ace - Americ ack, White,	
urs aft	۾	1 ☐ Never Married 2 X 3 ☐ Widowed 4 ☐ Divo		1 □ Yes 2 If Yes, Give Year or Date			1 □Yes 2M∏ No	Specify:		Spec	ify: B]	Lack
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filed v Hygic Sther ent,		12 years 17. Father's Name (First, Mid	die, Last))			Luon DIIV		me (First, Middle	e, Maiden Surna		,
uld be Venta irked tric ev	To Be	Ronald Haywo	od S	Simmons,	Sr.			Burst	elle Sm	ith 		
2 short and I is ma		19a. Informant's Name/Relat	ionship (Type.Print)			iling Address (Stree					Code)
1 and Health em 27 ther t		20a. Method of Disposition					Imperial		aurel,	20c. Location		own, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Important: If fiem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Madical Evarcination ust be notified at once.		1⊠ Burial 2 ☐ Cremat 4☐ Donation 5 ☐ Othe			ate Mou	cemetery, cr	position (Name of rematory or other pla ivet Cemet	tery Oct.			-	
permit. F Departm Importar any injur	ŀ	21. Spnature of Euneral Ser			N SOAA		22. Name and Addr	ess of Facility S	tewart	- Funeral	Home	Inc.
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		23a. Party Enter the disease shock, or heart failure.	a, or com List only	plications that cau one cause on eac	sed the dea h line.		4	_	c or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-	a	as a conse		129	4				
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eath certificate be executed attending physician and for use as the burial-transit			l	d								
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attend for use	jan/	23b. Was decedent pregnantin the past 12 months?	1		me of pregr th 2 Fet nt at time of	al déath	3 Ectopic pregnan	псу			ate of delived	ery Day Year
that the de	Physic	1 □ Yes 2 □ No 9 □ Unknown		9 Unknov		ueaui ;	5 ☐ Other (specify) _					
The law requires that the death certificate be ate has been signed by the attending physicia bage 2 should be detached for use as the burn	by Pi	Part II. Other significant cor	ditions	contributing to dea	th but not re	sulting in the	underlying cause gi	iven in Part I.	23e. Did	tobacco use co	ntribute to t	he cause of death?
w requires that s been signed to should be detailed		0		TNE	- 001		- empt3		1 [Yes 2 No	3 ☐ Pro	bably 4 Unknown
e law has b	Completed	TASI	′ 3	acid	e 1	417-	emp 15		24a. Wa aut	s an 24b opsy formed?		opsy findings available ompletion of cause of
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agi isi	0 0	examiner?	21001	Hospital:	patient 2	BR/Outpat	tient 3 DOA Ot	ther: 4 \(\sum \) Nursing			ther (Speci	(fy)
Jing Ph After th funeral	on: T	27. Manner of Death 1 ☐ Natural 5 ☐ Pe	nding	28a. Date of (Month)	Day, Year)	28b. Time Injur	of A 28c. Inju	ury at ork?	28d. Describe	how injury occi	urred 17	and my t
death.	cati	3 Suicide 6 Co	estigation ould not b	e 290 Place o		- W	street, factory, office	Yes 2 No	28f. Location	(Street and Nur	nber or Rur	al Route Number,
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			lical Exar	miner: On the bas	is of examin	ation and/or	eath occurred at the	opinion, death occ	curred at the time	e, date and place	manner as e, and due	stated. to the cause(s)
the H thin 24 the F mplete	Medical	one) 29b. Signature and title of ce	rtifier	and manne	r stated.		29c Licer	nse number		29d. Date sign	ned (Month.	Dav. Year)
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	Physicia	n/	1. Decedent's Name (First, Middle, Last)	-				2. Date of Dea	ath	3. Time of Death
	Medic	al	Elizabeth Simmons 4a. Facility Name (if not institution, give street and not institution).	umber)		4b. City, Town, or	Location of Death	Octobe	r 14, 2009	
مريد	Examin	er	Washington Adventist			Takoma			Montgon	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Aug. 2	9. (^{Year)} 8, 1928 Wa	Birthplace (State or Foreign Country) ashington, Ga.
	ov at	r	Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or L	ocation				10d. Inside City Limits
	farylar Ba-fsh tified	ecto	Maryland Prince George			l Heights				1 🖾 Yes 2 □ No
	a or 20	al Dir	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	th with ms 23 must	Funeral Director	20 Maryland Park Dr.		140	2074		" V N	United S	
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	Armed		13.	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes ② No	, Mexican, Puerto	Rican, etc.)	14. Race - A Black, W Specify: I	
15-0	72 hou I "natu edical	Completed	15. Decedent's Education (Specify only highest grade complete	ed)	(Give	edent's Usual Occupa kind of work done do		ing	16b. Kind of Busine	ess Industry
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nd	filed v al Hyg d othe	o Be	17. Father's Name (First, Middle, Last)						Maiden Surname)	
Ŋa	uld be d Ment narke natic	오	William Butler	Т				Williams		
	12 shoulth and 27 is i		19a. Informant's Name/Relationship (Type, Print) Venus Simmons-Miller/	Daughter		ing Address (Street a				
ore,	of Head if item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro	20b, Pla	ce of Disp	osition (Name of		Date	20c. Location - City	
Baltimore,	t. Page 1 tment of tant: If it		4 Donation 5 Other (Specify)	Mar	y1ánc	matory or other place Veterans	10/2	1/09	Cheltenha	m, Md.
Ba	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	2 MOIUSS			S. Pope		stville, M	D. 20747
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on	at caused the death. ach line.	Do not en	-				Approximate Interval Between
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_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check 2 Medical Examiner: On the bonly one) 3 Certifying Nurse Practione	asis of examination a	and/or inve	stigation, in my opinior	n, death occurred a	the time, date ar	nd place, and due to the	he cause(s) and manner stated.
	vith vith Total		29b. Signature and title of certifier			29c. License	number 280	1	29d. Date signed (Ma	onth, Day, Year)
	R8		30. Name and address of person who completed ca	use of death (Item 2	3a) (Type,	Print) RPPP	Ave.	Tako	ma po	PK, ND
	Stat Registra		31. Date filed (Month, Day, Year) OCT 2 0 2009 Server 32.	Registrar's Signatur	"Med		10			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month / SHIPPLING 8:57 PM W HENY 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Prince George's Laurel If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 X M 2 □ F 86 November 14, 1922 Heinrichau, Germany 185-18-6537 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 No Maryland Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6109 62nd Place 20737 USA 12, Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1946–1949 1 ☐ Yes 2 🖾 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adolph Shippling Louise Granitza 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greta Shippling / Wife 6109 62nd Place, Riverdale, MD 20737 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/19/2009 Fort Lincoln Cemetery Brentwood, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue RAS RUGERS Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Approximate Interval Between Onset and Death Brain Death Due to (or as a consequence of): Anoxic Encephalopathy Due to (or as a consequence of) Cord Compression Due to (or as a consequence of) GERTIFICATION 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown

Physician /Medical Examiner

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/Medical

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Baltimore, Maryland 21215-0036

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d other than "natural", or items 23a or 28a-f shov event, the Medical Examinatory to empiliad at

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law requires that the death certificate be exec Box 68760, P. 0. Division of Vital Records, Hospital or Attending death. after death Director: completely filled in by the

e Funeral I within 2 State

23a. Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitus 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Sepsis; Spinal Stenosis, Coronary Artery Disease 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 15 NO 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Year) 5 Pending investigation Natural 10/01/09 2 Accident Unknown M 1 ☐ Yes 2 XNo Subject fell 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6109 62nd Place 4 Homicide Riverdale, MD 29a, Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George Ita Okang, 7503 Surratt Road, Clinton, MD 20735

D41248

10/10/2009

	1 For State Registrar	State of M	arylan	d / Depa <i>Cer</i>	artment o	of Hea	lth ar	nd Me	ental Hy	giene , Reg. No.	2009	35	148
ian/	Decedent's Name (First, Middle, Last) Paul Edwin Schaub								2. Date of Dea Month October	ath Day	2009 2009	3. Time of 9:30	_
ical iner	4a. Facility Name (if not institution, give s Collington Nursing	treet and number)		_	4b. City, Tov	wn, or Loca		Death		4c. C	ounty of Deat		
l r	727-01-0863	7. Ag	e (In yrs. la 92	ast <i>birthday)</i> Yrs.	If Under 1 Months D		Jnder 24 ours	Min.	3. Date of Birt <i>(Month, Day</i> June 18	h (Year) 3, 191	9. Birt Cou O k	thplace (State of untry) Lahoma	r Foreign
Director	Usual Residence of Decedent 10a. State 10b. County Maryland Calvert		,	y, Town or Loc Hunting								10d. Inside C	ity Limits
ral Dir	10e. Street and Number 1100 Carson Drive				10f. Zip Co		639			10g. Citize	n of What Co	untry?	
d by Funeral		12. Was Decedent E Armed Forces? 1 🔀 Yes 2 🗌 If Yes, Give	No	If	Vas Decedent Yes, specify	t of Hispan Cuban, Me	ic Origin exican, P	n? (Specit Puerto Ric	fy Yes or No- can, etc.)		. Race - Ame Black, White		_
Completed	15. Decedent's Edu (Specify only highest grad	e completed) College (1-4 or 5		(Give k life. DC	ent's Usual C kind of work of NOT use re	lone during tired)		f working		16b. Kind	of Business		arv
To Be C	17. Father's Name (First, Middle, Last) Paul Schaub, Sr.	4		ACC	counta		Mother's	s Name (i	First, Middle,			i ireasc	Unav
	19a. Informant's Name/Relationship (Type Deborah Distad /	_{e, Print)} Friend		1	-						wn, State, Zip 20639		
F	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		CE	lace of Disposemetery, cremodel 1	natory or othe	r place)	10	Da	te /2009		ition - City or	Town, State , Maryl	and
	21. Signature of Funeral Service License	tman		- 1	. Name and A			Hom	e, PA			more Av .e, MD 2	
dical Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last	Due to (or as a Due to (or as a	a consequ a consequ	ence of):								Interval Bet Onset and 1 Year	
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ed by Pr	Part II. Other significant conditions cor	_		ulting in the u	nderlying cau	se given in	Part I.					the cause of d	
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To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	ent 2 🗆 I	ER/Outpatien		26. Place o				ence 6	Other (Speci	ifv)	
Certificate: 7	27. Manner of Death 1 🖾 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28a. Date of inju (Month, Day 28e. Place of Inju	ry y, Year) ury - At hor	28b. Time of injury	28c.	Injury at work? 1 Yes		0 28	d. Describe h	ow injury o	ccurred	ral Route Numb	per,
Medical Ce	29a. Certifier 1 🔀 Certifying Physic (Check 2 🗌 Medical Examin	er: On the basis of e	my knowle	edge, death o	igation, in my	opinion, de	eath occu	urred at th	e time, date a	use(s) and r	nd due to the o	cause(s) and ma	inner state
Σ	only one) 3 Certifying Nurse	Practioner: To the	pest of my	r knowledge, d		cense num D47	ber	nd place,		29d. Date s	nd manner as signed (Month	n, Day, Year)	
	30. Name and address of person who co				,	Mitch	ellv	7 i 114	e, MD :		·		
ate	31. Date filed OCT 2 0209	32. Registra			4				,				

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland Department of Health and Mental Hygiene 2009

Certificate of Death Reg. No. 1 - For State Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day -1245 AM SEAN WATSON STURM 0 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Coastal Mospice Salisburd Wicomico at Lake 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days 218-16-6336 1 □ M 2 KF 85 5/12/1924 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Wes 2 □ No MD HEBRON WICOMICO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21830 411 WALKUT ST. 411 E. Walnut ST. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔣 No Specify: Specify: WHITE 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Book keeper INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) STUTM Lloyd T. Watson MAE WRIGHT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GAIL HARMORE POBOX 42 412 E WALNUT ST. HEBRON, 170 21830 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HEBRON Cometer 10-11-2009 HEBRON, MED 22. Name and Address of Facility

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18. Na 21. Signature of Funeral Service Licensee 23a. Part1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARCINOMA MALIQNANT LUNG disease or condition resulting in death) Due to (or as a consequence of): MALIGNANT CARCINOWA Samuentically list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

/Medical Examiner or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, er this certificate had sral director, page 2 After th funeral the Funeral Director: Aft

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Medical

29a. Certifier

29b. Signature and the of certifier

31. Date filed (Month, Day, Year) OCT 19

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylal Department of Health and Mental Hygiene Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment with the natified at once.

Physician

Maryland 21215-0036

Baltimore,

To the Hospital o within 24 hours aff To the Funeral Di completely filled in

Registrar

and manner stated.

P.O BOX

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

10058410

29d. Date signed (Month, Day, Year)

			1 - State Amend Item Registrar	as 25,27,28	Maryland a-f pe i	/ Depa r me , g <i>Cer</i>	rtment of Healt 1970 tificate of Dea	gan d N oth	lental Hy	giene, Reg. No.	2009	351	50
	Physicia	an	1. Decedent's Name (First, Middle			_			2. Date of De Month	eath Day	Year	3. Time of D	eath
	/Medic	al	Marie E. Taylo 4a. Pacility Name (If not institution		er)		4b. City, Town, or Locat	tion of Death	10	/5	2009 County of Death	8:31	- IVI
	Examin	er	Coastal Ho	100	-1	Ake	Sali	SbUL	4	1	-	nico	
	Funeral		5. Social Security Number		Age (In yrs. las	st birthday) Yrs.	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. urs Min.	2. Date of Bi	ay, Year)	9. Birthp Cour	lace (State or ntry)	Foreign
	Director		222-09-1498 Usual Residence of Decedent	-X	<i>3</i> i	115.			Nov 22	, 191	7 DI	<u> </u>	
	ryland how Lat	_	10a. State 10b. County		,	Town or Loc					1	0d. Inside City	
	he Ma 8a-f s	Director	DE Susse	X	Mil	lsboro				10a Cikin	zen of What Cour	1 ⊠Yes	2 NO
	with the sa or 2	اق	10e. Street and Number 26544 Handy Roa	d			10f. Zip Code 19966			rog. Citiz	USA	iti y :	
	death	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S.	13. V	/as Decedent of Hispanio Yes, specify Cuban, Mex	c Origin? (Sp	ecify Yes or No	o- 1	14. Race - Americ Black, White,		
0500-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Marri 3 🛣 Widowed 4 ☐ Divorced		No No			ecify:	, , , , , , , , , , , , , , , , , , , ,		Specify: Af	rican- merican	,
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VISION	Atter er dea rector by the	Certification:	3 Suicide 6 Could r 4 ☐ Homicide determ	not be 28e. Place of	-,	ne, farm, stre	et, factory, office		28f. Location	(Street an	d Number or Flurd	26544	oer,
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	ne Hosp n 24 hoi ne Fune oletely fi	Medical		Examiner: On the bas and manne	is of examination	on and/or inv	occurred at the time, da restigation, in my opinion	n, death occur	red at the time	, date and	place, and due t	o the cause(s)	1
	To the within	Ž	29b. Signature and title of certifier	•			29c. License num	ber		29d. Dat	te signed (Month,	Day, Year)	
	5.				-f -lAl- (1)	20-) (=	1005	841	0		10/16/	09	
	M		30. Name and address of person	wno completed cause	or death (Item 2	zsa) (Type, F L	29c. License numi DO 05 Print) +05 PICIZ	20	Bo x 17	375	Kusnu	iguy 2	1802
	Sta		31. Date filed (Month, Day, Year)	2000 32 Rec	jistrar's Signatu	ye /	Ned.					/	
	Registr	ar	001 15	C003 CE	ua p	· HIP OF	U was						

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State of Maryla	and / Departmer	nt of Health	and Mental	Hygiene

Seorge William	۷ä,	1-For State Registrar	and / Department of H Certificate of D		ygiene Reg. I	2009 3515
Physici Medical Exam		Decedent's Name (First, Middle,Last) George William	a Varner		2. Date of Death	3. Time of Death
		4a. Facility Name (if not institution, give street and nu 18032 Maugans Avenue	mber) 4b. 0	City, Town, or Location of Death		4c. County of Death Washington
Funeral Director		5. Social Security Number 6. Sex 1 X M 2 F		Under 1 Year If Under 24Hrs Months Days Hours Min		MM/DD/YYYY) 9. Birthplace (State or Foreign 1958 Periods y 1 vania
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Washington 10e. Street and Number 18032 Maugans Ave. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade or Dates: Elementary/Secondary (0-12) College (1) 12 17. Father's Name (First, Middle, Last) Roger P. Varner, Sr. 19a. Informant's Name/Relationship (Type, Print) Roger P. Varner, Sr./Fat 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from the property of	edent Ever in U.S. 13. Was Derices? 2 X No 1 Yes le completed) 16a. Decedent's U during most of the chani 19b. Mailing Add 18032 M 18032 M 20b. Place of Disposition crematory or other p Smithsburg 22. Name	18. Mother's Name Margare dress (Street and Number or I laugans Ave., I (Name of cemetery, olace) Crematory 10/	work done red) work done (First, Middle, Maio et Ann You Rural Route Number Hagerstown Date 27/2009	ung r, City or Town, State, Zip Code) n, MD 21740 Oc. Location - City or Town, State Smithsburg, MD Funeral Chapel
Physician /Medical xaminer	edical Examiner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a b. Due to (or as a c. Due to (or as a d.	sused the death. Do not enter the m	aoral shotgun	or respiratory arrest,	shock, or heart Approximate Interval Between Onset and Death
Records, P.O. Box 6876(The law requires that the death certificate ficate has been signed by the attending phy. page 2 should be detached for use as the b.	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?	rth 2 Fetal do ant at time of death 5 Other wn	eath 3 Ectopic pregna	23e. Did tobac 1 Yes 2 24a. Was an autopsy performer	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - transit	Medical Certification: To Be Co	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 29a. Certifier (Check only) 28a. Date (Month) 28a. Date (Month) 28b. Place (Specify) 28c. Place (Specify)	of Injury - At home, farm, street, fact Single Family Home of my knowledge, death occurred at fexamination and/or investigation, is	28c. Injury at Work? 1 Yes 2 ✓ No ctory, office building, etc. at the time, date and place, and	28d. Describe how Subject shot so 28f. Location (Stree or Town, State 18032 Maugans A due to the cause(s) it the time, date and	idence 6 Other: Scene injury occurred elf et and Number or Rural Route Number, City Avenue, Maugansville, MD
3 >		30. Name and address of pyrs who completed cause	e of death (Item 23a) al Examiner 111 Penn S	O.C.M.E.	O	October 25, 2009

OCME 2006

State Registrar

State of Maryland / Department of Health and Mental Hygiene 35152 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 10:00a M 10/19/2009 Lillian Wexler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arden Courts Assisted Living Montgomery Kensington 8. Date of Birth (Month, Day, Ye March 3, If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Year 1 □ M 2 🖾 F Director 91 1918 MA 014-12-8329 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County the Medical Exeminer must be notified at Director 1 XYes 2 No "none" DC Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a Funeral 5410 Connecticut Avenue, NW, #811 20015 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 21√∑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🖾 No þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, In Men College (1-4or 5+) 5+ Elementary/Secondary (0-12) United States Army Meteorologist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Sarah Shapiro Harry Lubin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5410 Connecticut Ave, NW, #811, Washington, DCJoan S. Wexler - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 10/21/2009 Westview Cemetery Lexington, MA 4 ☐ Donation 5 ☐ Other (Specify) gnature of Fun ral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. MO1255 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1 finter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cerebrovascular Disease /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (unas a consequence of): be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760 Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 Tyes 2 No Ö been signed by the should be detached 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Hypothyroidism Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Hyperlipidemia cate has t page 2 s autopsy performed certificate 1 ☐ Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Așsisted 1∐ Yes 2 🙀 No Other: $_{4}\square$ Nursing Home $_{5}\square$ Residence $_{6}$ \times Other (Specify) $\overline{\text{Living}}$ Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signatu title of certifi 29c. License number 29d. Date signed (Month, Day, Year) H45839 October 19, 2009 30. Name ar Dr Gary E address q person who completed cause of death (Item 23a) (Type, Print) 1119 Rockville Pike, #316, Rockville, Maryland 20816 Raffel, 31. Date filed (Month, Day, Year) Registrar's Sign State 20 OCT Registrar

			For State Registrar	State of Ma	aryland	-	artment of F rtificate of a		and Mental	Hygier Reg. N	200	9 35153
	Physici		Dora Joyce	Westfall				A 4440 AR	2. Date Monti	of Death	Day Ye	3. Time of Death
Was .	/Medio Examin		4a. Facility Name (If not institution, 1. Social Security Number 220–30–8447	Adock C	AMOL e (In yrs. Ia:		4b. City, Town, or If Under 1 Year Months Days	DER!	er 24 Hrs. 8. Date		W)_ 0	Birthplade (State or Foreign
ŀ	Director		Usual Residence of Decedent	1 L M 2 S F 7	5	Yrs.			Dec.	3, 13	933 M	laryland
	farylan show	or	10a. State 10b. County MD. Allega	nv		Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 XNo
	h the Nor 28a-1	Director	10e. Street and Number	-			10f. Zip Code			10g.	Citizen of Wha	t Country?
	sath wil		21314 Donna	St.	Francia (I.C.	10.1	2156		Ovining (Specify Vec		ited St	American Indian,
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. In Indice Evan Institute Institute on Once.	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced	Armed Forces?			was Decedent of Plantif Yes, specify Cuba	Speci	Origin? (Specify Yes can, Puerto Rican, etc	5.)	Black, V	white etc.
21215-0036	within 72 h ene. than "natu he Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12	s Education grade completed) College (1-4or 5	i+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during m d)	ost of working	- 64	Kind of Busine	
and 2	id be filed ental Hygi ked other Ic event, I	To Be Co	17. Father's Name (First, Middle, L	ast) ilkinson					ther's Name (First, M	liddle, Maid l iv an		
, Maryland	and 2 shou salth and N 27 is mar	-	19a. Informant's Name/Relationsh Rhonda Westfall						nber or Rural Route I Lonaconin			ite, Zip Code) 21539
altimore,	Pages 1 ament of He ant; If Item ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp.				esition (Name of matory or other place emetery	ce)	10/25/ 2009	i		y or Town, State ort Maryland
Balt	permit. Depart Import any Inj once.		21. Signature of Funeral Service L	icensee	l		2. Name and Addre		., Western		l Home Marvlar	nd 21562
1	Physician /Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	complications that caused only one cause on each line.	the death.		ter the mode of dyir	ng, such				Approximate Interval Between Onset and Death
	Examiner	<u>.</u>		Due to (or as								
	scuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Liner underlying Cause (Disease or injury that initiated events	Due to (or as	a conseque	ence or):						
38760,	icate be executed physician and s the burial-transit	dical Ex	resulting in death) Last	Due to (or as	a conseque	ence of):						
$\overline{}$			IF FEMALE:	23c. If yes, outcome								
P.O. Box	law requires that the death certifi as been signed by the attending 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 25 No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	У		_	23d. Date o Month	
Records, F	w requires that the de s been signed by the a should be detached i	þ	Part II. Other significant condition	•	ut not result	ting in the u	nderlying cause giv	en in Pa	rt I. 23e.	Did tobacc		te to the cause of death? ☐ Probably 4 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
_	The ate h	Completed	1) VARION	Carrier in	hub	Ann	less.	Tret	24a.	Was an autopsy performed	? prio	re autopsy findings available r to completion of cause of th?
Vita Vita	ding Phystotan: The I h. After this certificate ha funeral director, page	Be	25. Was case referred to medical examiner?	Hospital:	(Oth	or:	ace of Death (Check	only one)		
o L	ng Physter this neral di	n: To	1 Yes 2 No 27. Manner of Death T Natural 5 Pending	28a. Date of Inju	iry 2	R/Outpatier 28b. Time o Injury	N 3 L DOA	y at	Nursing Home 5 28d. Des		e 6 ☐Other (njury occurred	(Specify)
Division of Vital	or Atten ifter death Director; in by the	Certification: To	T_nNatural 5	ation of be	ury - At hon	ne, farm, str		Yes 2	28f. Loca	tion (Street or Town, St	t and Number (tate)	or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical C	29a. Certifier 1 Gertifyin (Check only 2 Medical I	g Physician: To the best examiner: On the basis o and manner sta	of examination	/ledge, deat on and/or ir	h occurred at the ti	me, date	and place, and due death occurred at the	to the caus time, date	e(s) and mann and place, and	er as stated. If due to the cause(s)
	To the within 2 To the comple	M	29b. Signature and title of certifier				29c. Licens	e numbe	er			Month, Day, Year)
		11	30. Name and address of person of	who completed cause of d	leath (Item	23a) (Type	Print)	24	-4		10/23	109
		T	DR. Jesus 7	an 4 Br	TOAC	WAY	Frost	bu	rg, mo	215	32	
	Sta Registi		31. Date filed (Month, Day, Year) OCT 2 3		ar's Signatu	ire bo	gold					

State of Maryland / Department of Health and Mental Hygien 2009 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) $c^{\text{Day}}15,2^{\frac{1}{0}0}09$ October **Physician** Douglas Norman Willman 2:00pM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 13669 Clear Spring Road Clear Spring Washington 8. Date of Birth (Month, Day, Year) 6-1-1938 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min 1 ₹M 2 ☐ F 71 214-36-0816 Yrs. Hagerstown, MD Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in then "natural", or Items 23s or 28s-f ehow the Medical Examiner must be notified at MD Washington Clear Spring 1 Yes No Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21722 U.S.A. 14610 Mercersburg Rd. e tiled within 72 hours after death val Hygiene.
I dyner then "natural", or Items 23s Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11 Marital Status Black, White, etc. Specify: White 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) newspaper printing nentary/Secondary (0-12) College (1-4or 5+) shipping/receiving dept company 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be tile Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event ange: 17. Father's Name (First, Middle, Last) Robert Luther Willman Lillian Florence Morganthall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13669 Clear Spring Rd. Clear Spring, MD 21722 Terry L.Willman brother Oct. 20, Clear Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Little Rose HIll 2009 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc 21. Signature of Funeral Service Licenses Karlin P.O.BOX 310 Clear Spring, MD 21722 ron Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final can (e) ancheatic **Physician** disease or condition resulting in death) /Medical Due to (br as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ል 1 Yes 2 No 3 Probably 4 Nnknown certiticate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmed2 2/X No 1 ☐ Yes 2 ☐ No 1 Yes Hospitel or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death Check only one examiner? Other: 4 Nursing Home 1 Yes 2 No Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Atter this c 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hin 24 hours e 29a. Certifier 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mariner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 cut lay , Mass 30. Name and address of person who completed cause of death (Item 23a)-(Type, Print) Opal 1130 Youg VH-12 large 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 2 1 2009

State of Maryland / Department of Health and Mental Hygiene

35155 Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle, Last) 10-10-2009 Vear **Physician** CLARENCE GARY WILLIAMS 7:55 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 09-24-1951 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 1 M 2 □ F **Funeral** Min. Months Days Hours 437-78-7478 58 LOUISIANA Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 28a-f show event, the Medical Examiner must be notified at 1X Yes 2 □ No Director MD MONTGOMERY SILVER SPRING 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a or 20910 9009 ALTON PARKWAY U.S.A. Completed by Funeral filed within 72 hours after death Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐Wo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 YEARS CAR SALESMAN TISCHER NISSAN/ACURA and Mental Hygi 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic event ones. 17. Father's Name (First, Middle, Last) Be ပ VIVIAN ABRAHAM WILLIAMS, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) KATHRYN WILLIAMS/ WIFE 9009 ALTON PKWY. SILVER SPRING, MARYLAND 20910 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 1 Burial 2 □ Cremation 3 □ Removal from State ST. JOSEPH CEMETERY 10-17-2009 PAULINA, LOUISIANA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2. Name and Address of Facility JOHN T. RHINES FUNERAL HOME LLC 3005 12th STREET N.E. WASHINGTON, DC 20017 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE RESPIRATORY FAILURE /Medical Due to (or as a consequence of) **Examiner** SEVERE HYPERCARBIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed ADVANCED RENAL CARCINOMA burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 No certificate 2 🗆 No 1 □ Yes of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred **Division** 1 ANatural s after dea. 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a To the Funeral L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D65305 10-11-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. NABILA KHAN 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND 20910 NABILA KHAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 n 2009

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of N	laryland / De	partment of F ertificate of			iene eg. No.2009	35156
	Physici	an l	1. Decedent's Name (First, Middle, Last)					Date of Death Month	h Day Year	3. Time of Death
	/Medic		FLOYD ER	NEST V	VILSON			OCTOBER	12, 200	
	Examir	er	4a. Facility Name (If not institution, give s	_			r Location of Deat	h	4c. County of Dea	
32			4006 Silver Par 5. Social Security Number 6. Sex		ace Age (In yrs. last birthda	Suitla	and If Under 24 Hrs	8. Date of Birth		Georges thplace (State or Foreign
١,,	Funeral Director		229-62-2491	. 7. A M 2□F	V	Months Days	Hours Min.	(Month, Day,	Year) Co	ountry)
1			Usual Residence of Decedent		60 118			March	4,1949	VA
	yland now		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Marfst iffed	tor	MD PG		Suit	land				1 ∑ Yes 2□No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What Co	ountry?
	23a Ust b		4006 Silver Par			207	46	U	nited St	ates
	r dea	Funeral	11. Marital Status	 Was Deceder Armed Forces 	nt Ever in U.S. 1	Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi	
36	s afte	by Fi	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	If You Give	^{1 No} 1 9 7 1 : VIETNAM	1 ☐ Yes 2 🔀 No	Specify:		Specify:	1
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at		15. Decedent's Educ			cedent's Usual Occur	nation		16b. Kind of Business	ack /Industry
5	in 72 n "na Medic	Completed	(Specify only highest grade	completed)	(Gi	ve kind of work done b. DO NOT use retire	during most of wo	rking	TOD. TAING OF BUSINESS	middsiry
212	I within jiene.	E	Elementary/Secondary (0-12)	College (1-4o		il Handl	er		US Post	Office
	be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or ftems 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)			-	18. Mother's Na	me (First, Middle, M	Maiden Surname)	
Maryland	should be and Mental s marked o umatic eve	5	James Wilson				Inez	Fox		
lar)	s m		19a. Informant's Name/Relationship (Type	,					City or Town, State,	Zip Code)
	C - O -		Linda Wilson/wi	fe		6 Silver				
Baltimore,	of the		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ R	emoval from Stat	cemetery, o	sposition (Name of rematory or other pla	ce) 10/2	0/09	20c. Location - City or	Town, State
ţ	tmen tant:		4 □ Donation 5 □ Other (Specify)		Md. Vet	erans Ce			heltenha	
Bal	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service License	ee	/	1		-	Edwards	
		_	23a. Pary. Enter the disease, or compli	COUNTY	ed the death. Do not					, Md. 20746 Approximate
			shock, or heart failure. List only or	e cause on each	line.	enter the mode or dyn	ig, such as cardia	c or respiratory arre	=5t,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		ATIC COLON	CANCER				
	Examiner			Due to (or a	as a consequence of):					
١,		ē	Sequentially list conditions, if any, leading to immediate	Due to (or a	as a consequence of):					
	outed d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
o,	be executed sician and burial-transit		resulting in death) Last	Due to (or a	as a consequence of):					
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical							· · · · · · · · · · · · · · · · · · ·	
မွ	ertifica ing pt	Med	IF FEMALE:							
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pregnanc	у		23d. Date of de Month	elivery Day Year
0	at the de by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant 9□Unknown		5 ☐ Other (specify) _				2-,
0	that the		Part II. Other significant conditions cor	tributing to death	but not resulting in the	e underlying cause giv	ren in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
or Vital Records,	uires signi	d by	POST TRAUMATIC ST	RESS DIS	SORDER			1 □ Y	es 2∏No 3∏F	Probably 4 Unknown
COL	w require been sign	Completed						24a. Was a	n 24h Were s	uutonev findinge available
Re	The lav	ш						autops perforr	ned? death?	utopsy findings available completion of cause of
ta			25. Was case referred to medical				26 Place of De	ath (Check only on	21/2No 1 LIYe	s 2DXNo
>	Physician: this certific ral director,	To Be	examiner?	lospital:	ıtient 2 ☐ ER/Outpa	tient 3 DOA Oth	or.	-	ence 6 Other (Sp	ecify)
ō	ding Ph .r. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of I	njury 28b. Tim Day Year) Injur				ow injury occurred	
10		atio	2 ☐ Accident investigation	(memi)		· _	Yes 2 □ No			
Division	for Attendated after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of building,	njury - At home, farm, etc. (Specify)	street, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
	ospital or Atten hours after deatf uneral Director:		X							
	Hos Fun tely	edical	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exami	sician: To the be ner: On the basis and manner	st of my knowledge, do of examination and/o	eath occurred at the ti r investigation, in my	me, date and plac opinion, death occ	e, and due to the courred at the time, d	ause(s) and manner a late and place, and du	is stated. le to the cause(s)
	To the Hos within 24 ho To the Fun completely	Mec	29b. Signature and title of certifier	and manner	stated.	29c. Licens	se number	2	9d. Date signed (Mor	oth. Dav. Year)
	F≥Fŏ		* CIMIR DOMS	Ken		#33	255		TOBER 13,	
,	111		30. Name and address of person who co	mpleted cause o	f death (Item 23a) (Tur					
R	3+1		The second second		111 - 111		TREET NU	WASHING	TON DC 201	122/688
	Sta	ate	31. Date filed (Month, Day Year)	22 Bodi	trar's Signatura	TRATEG D	TIME IN	, WADILING	TORISTO ZU	122/000
State Registrar OCT 2 0 2009 Annual Property of the Registrar Regi										

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** WILLIAMS LEROY OCTOBER 2009 11:00A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE S CAPITOL HEIGHTS AVENUE 1809 NOVA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 □ F 61 578-64-0886 Director 1948 WASHINGTON, DC MARCH 1 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the "ledge Examinar most be rediffied at 1 No 2 No Director CAPITOL HEIGHTS PRINCE GEORGE'S 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20743 1809 NOVA AVENUE Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 72 hours after BLACK 1 Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: ð 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) GOVERNMENT MAIL CLERK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi LILLIAN WIGGINS BOYSIE WILLIAMS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 307 WILLOW HILL PLACE HYATTSVILLE, MARYLAND 20785 item 27 i BRENDA PROCTOR/SIGNIFICANT OTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition Pages 1 trent of t permit. Pages
Department of
Important: If it
any Injury or o t Burial 2 ☐ Cremation 3 ☐ Removal from State 10-21-2009 | LANDOVER, MARYLAND HARMONY CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) nature of Funeral Service Licensee 22. Name and Address of Facility J. B.JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Malignant Neoplasm Prostate disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) physician sthe burial Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Ye ar in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) signed by the a d be detached for P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown has been signed by the position of the positio Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 1 □ Yes funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 \sum Nursing Home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 54 Residence 6 ☐ Other (Specify) 1 Tes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No ours after death. neral Director; A filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal within 24 hou

To the Fune

completely fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of dertifier 4(06665 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h, Day, State Registrar

		-	For State Registrar	State of Marylan	u / Depa Cer	tificate of D	eath	Re	ene 20	09	35158
	ysicia		1. Decedent's Name (First, Middle, Las Billie	r) Ross	Watts	3		2. Date of Death October]		Year	3. Time of Death
	Medic xamin		4a. Facility Name (if not institution, give	2		4b. City, Town, or I	Location of Death	3000000	4c. County	of Death	11.17/1
1			Southern Maryland Hos			Clinton			Princ	e Geor	
	neral ector		223-28-3928	ex ☐ M 2xxF 7. Age (In yrs. Ia 87	est birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth April 10,	Year 922	9. Birthpi Count	ace (State or Foreign Virginia
ryland	-f show ied at	ctor	Usual Residence of Decedent 10a. State 10b. County		y, Town or Loc		-			10	0d. Inside City Limits
e Ma	or 28a notifi	Dire	Maryland Prince Go	orge's le	mple Hil	10f. Zip Code		10	0g. Citizen of V	Vhat Count	
with th	s 23a o	Funeral Director	2411 Keating Street			2074	i8	"		USA	,.
death	ner m	F	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13. V	/as Decedent of His Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto	cify Yes or No- Rican, etc.)		e - America k, White, e	
Maryland 21215-0036 2 should be filed within 72 hours after the and Mental Hygiene.	7 is marked other than "natural", or items 22a or 28a-f show traumatic event, the Medical Examiner munt be notified at	Completed by	1 ☐ Never Married 2 ☐ Married 3XXX Widowed 4 ☐ Divorced	1 ☐ Yes 2 XXNo If Yes, Give Year or Dates.		☐ Yes 2xc No			Specify:		
15-(r"nat ledica	nple	15. Decedent's Ed (Specify only highest gra	de completed)	(Give k	ent's Usual Occupa ind of work done du O NOT use retired)	tion uring most of worki	ng	16b. Kind of Bu	ısiness Ind	ustry
212 within giene.	er tha	S	Elementary/Seconday (0-12)	2 years		ry of Steno	ography		Federal	Gover	nment
filed tal Hy	event	To Be	17. Father's Name (First, Middle, Last) George Willie	Ross			18. Mother's Name	e (First, Middle, Ma Noel		,	
Tylen be Men	27 is marke traumatic	-	19a. Informant's Name/Relationship (Ty		40h Adailia	g Address (Street ar	Lera		Goode		a dal
- · · ± c	r trau		Billie Sue Durham / D	,	1	onny Drive			21550	tate, zip O	000
Baltimore, bermit. Page 1 and Department of Heal	If item 2		20a. Method of Disposition 1XXXBurial 2 ☐ Cremation 3 ☐			sition (Name of natory or other place	a) i		20c. Location -	,	
ti. Page 1	rtant: njury o		4 Donation 5 Other (Specify) Res		n Cemetery	10/21		Clinton		
Balti permit. Departr	Important: If its any injury or of once.		12/0 1	lup	6	Name and Address 160 Oxon Hi	11 Road Ox		aryland	eral H 2074	
	ician/ edical miner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	plications that caused the deat ne cause on each line. a	670	r the mode of dying	, such as cardiac o	r respiratory arres	st,	2	Approximate Interval Between Onset and Death
		iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	ience o'):						
ecuted	transit	Examiner	Cause (Disease or ilnjury that initiated events resulting in death) Last	c	ience off:						
68760 certificate be executed	pnysician and s the burial-transit	edical E	resulting in death) East	d							
8760 ifficate b	as the	Medi	IF FEMALE:	u					- 1		
	speen signed by the attending should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of of 9 Unknown	al death 3 🗔	Ectopic pregnancy Other (specify)	/		23d. Da Mo	te of delive nth	ry Day Year
cords, P.O. Box law requires that the death	signed by	þ	Part II. Other significant conditions of	ontributing to death but not res			en in Part I.	23e. Did tob			e cause of death?
Records, The law requires	should	Completed				•		24a. Was an			sy findings available
Rec The lay	are nas page 2	mo						autopsy perform	ned?	orior to cor death? I □ Yes	npletion of cause of 2 No
cian:	ector, p	Be	25. Was case referred to medical examiner?	Hospital:			ce of Death (Check				
Physic	r mis o	6	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatient 2 28a. Date of injury	ER/Outpatien 28b. Time of	t 3 DOA Other	4 U Nursing Ho	me 5 Resider			
on conding	ector, After finis certificate has by the funeral director, page 2.	icate	1 K Natural 5 ☐ Pending 2 ☐ Accident Investigation		injury	work?	Yes 2 No		,a., oooa		
Division of Vital To the Hospital or Attending Physician: within 24 hours after death.	d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		et, factory, office		28f. Location (Str. City or Town,		er or Rural	Route Number,
Hospita 4 hours	completed filled in	edical		sician: To the best of my know ner: On the basis of examination							
o the l	отре	Me		se Practioner: To the best of m			time, date and place	e, and due to the		nner as sta	ited.
F 3 F	- 0		1/12		Ma	D /8	3545	2	KVOBE	AI	5,2009
R	10		30. Name an underess of person who co	completed cause of death (Item	23a) (Type, P	D LINE	E CENT	ER U	ALDON	FIL	ld. Zets
R	Stat egistra		31. Date filed (Month, Day, Year) OCT 2 0 2009	32. Registrar's Signa	arks!						

		-	For State Registrar	State of Maryland / L	Certificate	of Death	Re	g. No.	35159
	Physicia	ın	1. Decedent's Name (First, Middle, Last	WASHINGTO	N		Date of Death Month	Day Yea	3, Time of Death
	/Medic Examin	al	HAZEL 4a. Facility Name (If not institution, give			vn, or Location of Death	OCTOBER	4c. County of De	ath
*			5419 RUXTON DRI		LANH		8. Date of Birth	PRINCE C	GEORGE 'S
	Funeral Director		377 32 1713	744 OF F		ays Hours Min.	MAY 9 19	15 ví	RGINIA
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
	e Mary 8a-f sh lifted	Director	MD PRINCE G	EORGE'S LANE					1 X Yes 2 □ No
	with th	Dire	10e. Street and Number 5419 RUXTON DRIV.	Ε	10f. Zip Co	ode 0706	10	g. Citizen of What (USA	Country?
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show if it item 27 is marked other than "natural", or items 20a to 28a-f show or other traumatic event, the Medical Evanirar must be published at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ ▼Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Deceden If Yes, specify 1 □ Yes 2 2	t of Hispanic Origin? (Sp. Cuban, Mexican, Puerto No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ar Black, Wh Specify: BI	merican Indian, nite, etc. LACK
Maryland 21215-0036	nin 72 hou e. In "natura Medical E	Completed by	15. Decedent's Edu (Specify only highest grade		Decedent's Usual C (Give kind of work of life, DO NOT use i	tone during most of work	king	6b. Kind of Busines	ss/Industry
7	filed with Hygiene ther tha ent, the	Com	7TH	I	OOMESTIC	18 Mother's Nam	ne (First, Middle, M	PRIVATE	
lanc	ild be fi fental H rked ot tic ever	To Be	17. Father's Name (First, Middle, Last) UNKNOWN			HATTIE	WASHING		
Mary	nd 2 should alth and Mer 27 is marke r traumatic		19a. Informant's Name/Relationship (T BARBARA WASHINGTO	vpe. Print) 19b N/GRANDDAUGHTER	Mailing Address (S 5419 RUX	treet and Number or Ru CON DRIVE LA	ral Route Number, ANHAM, MAR	City or Town, State CYLAND 20	e, Zip Code) 706
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Temovariioin State LIADMON	Disposition (Name ry, crematory or othe NY CEMETER			20c. Location - City	
Balti	permit. Departn Importa any Inju		21. Shatule of Fineral Service Licens	see	V.	Address of Facility ANDOVER ROAL		KINS FUNI ER,MARYLAI	
			23a. Part 1. Enter the disease, or composhock, or heart failure. List only of	lications that caused the death. Do one cause on each line.	not enter the mode o	of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Breast Cane Due to (or as a consequence					
	Examiner	<u>.</u>	Sequentially list conditions,	b. Due to (or as a consequence	of).				-
	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c.	01).				
60,	ifficate be executed g physician and as the burial-transit	al Ex	resulting in death) Last	Due to (or as a consequence	of):				
		fedical		d					
O. Box	ath cer uttendir or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pred 5 ☐ Other (spec			23d. Date of Month	delivery Day Year
ds, P.O.	w requires that the de s been signed by the a should be detached f	by	Part II. Other significant conditions of	ontributing to death but not resulting i	n the underlying cau	se given in Part I.	23e. Did tob		e to the cause of death? Probably 4 Unknown
Division of Vital Records,	sician: The law req certificate has bee irector, page 2 shou	Completed				1,000	24a. Was an autops perform	y prior ned? deatl	e autopsy findings available to completion of cause of h?
Vita	certifica ector, p	Be	25. Was case referred to medical examiner?	Hospital:		Othor	ath (Check only on		
n of	Attending Physician: r death. ector: After this certifica by the funeral director, p	ion: To	1 Yes 2 XNo 27. Manner of Death 1 XNatural 5 Pending	28a. Date of Injury (Month, Day, Year)		4 □ Nursing F injury at Work? 1 □ Yes 2 □ No		ence 6 Other (5 ow injury occurred	Specify)
Divisio	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined				28f. Location (St City or Town		r Rural Route Number,
_	the Hospital or hin 24 hours afte the Funeral Diru mpletely filled in I	Medical Co	29a. Certifier 1 Certifying Ph (Check only one)	ysiclan: To the best of my knowledg niner: On the basis of examination a and manner stated.	e, death occurred at nd/or investigation, i	the time, date and place n my opinion, death occu	e, and due to the curred at the time, d	cause(s) and manne late and place, and	er as stated. due to the cause(s)
2	To the within To the comple	Me	29b. Signature and title of certifier	_	29c.	License number	2	9d. Date signed (M	lonth, Day, Year)
	3		30. Name and address of person who	completed cause of death (Item 23a)	(Type, Print)	166665		Schake	11,2009
)		DONA LEGKUSKI	M.D. 9200 BASIL C	COURT LARG	O, MARYLAND	20774		
	Sta		31. Date filed (Moeth Day, Year) 200	32. Registrar's Siggature	parke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryla	Cer	tificate of D	Death	vientai riyţ	Reg. N	2009	35160	
	Physicia	ın/	Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		3. Time of Death	
	Medic Examin		ROPHER 4a. Facility Name (If not institution, give str	WALLACE, JR	•	4b. City, Town, or	Location of Death	OCTOBER		2009 c. County of Death	9:53 P M	
المرادة	£ Adiiiii	CI	HOLY CROSS HOSPITA				SPRING		40	MONTGO	MERY	
	Funeral Director		5/8 54 2638	M 2 □ F 7. Age (In yrs. 69	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt 09 20 1	940	g. Birth Cour	place (State or Foreign htry) DC	
	show dat	tor	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits	
	Mary 28a-f otifie	Director	DC			WASHING	GTON				1X Yes 2 ☐ No	
	th the 3a or t be n		10e. Street and Number	N 77 //010		10f. Zip Code			10g. C	itizen of What Cou	ntry?	
	ath w	Funeral	5120 SARGENT ROAD I	N.E. #ZIZ 2. Was Decedent Ever in U	I.S. 13 V	200		ecify Yes or No-		U.S.A.	oan Indian	
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	β	1 🕅 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates.		Vas Decedent of His FYes, specify Cubar		Rican, etc.)		Black, White,	etc.	
-	72 hou n "nat ledica	Completed	15. Decedent's Educ (Specify only highest grade		(Give I	lent's Usual Occupa kind of work done d		king	16b. k	Kind of Business In	dustry	
7	vithin liene. r thar the M	Col	Elementary/Seconday (0-12) 12th	College (1-4 or 5+)		O NOT use retired) ECTIVE OF	FFICER		F	EDERAL GO	OVERNMENT	
b	filed val Hyg d othe vent,	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, i			, , , , , , , , , , , , , , , , , , ,	
<u>yla</u>	Ment Ment narked	욘	ROPHER WALLAC	CE, SR.			CLA	JDINE		COOPE	₹	
Mar	12 should be alth and Men 27 is marke r traumatic		19a. Informant's Name/Relationship (Type	,		g Address (Street a					Code)	
	le 1 and tof Healt if item 2 or other		MARK HOLDBROOKS - C 20a. Method of Disposition			cArthur A	AVENUE CI	Date Date		07624 .ocation - City or To	own State	
Baltimore,	t. Page tment o tant: If jury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 9 ☐ Other (Specify) 21. Sig / ture of / uneral Service Links see	emoval from State Q1	JANTICO	NATIONAL		3-2009	TRI	ANGLE, V	IRGINIA	
Ba	permit Depar Impor any in		3005 12th STREET N.E. TWASHINGTON,								OUT LLC	
	Pnysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interpolate Cause (Final issease or condition at ATHEROSCLEROTIC CARDIOVASCULAR DISEASE									
فمب	Medical Examiner		Sulting in death)	Due to (or as a consec		KDIOVASC	DLAK DISI	LASE				
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or se a consec	quenes of).							
	ificate be executed g physician and as the burial-transit	ıl Exaı	that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):		_					
8760	ate be physici the bu	Medical	d.									
	ath certific attending for use as	Physician/Me	in the past 12 months?	c. If yes, outcome of pregn 1 Live Birth 2 Fe 4 Pregnant at time of	tal death 3 🗆	Ectopic pregnancy Other (specify)	/			23d. Date of deliv	ery Day Year	
О	at the d by tl letach		g ☐ Unknown Part II. Other significant conditions conti		esulting in the u	nderlying cause give	en in Part I	220 Did to	haaaa	una contributa to ti	ne cause of death?	
ds, P	requires that the de been signed by the should be detached	ted by									bably 4 Unknown	
Records,	sician: The law re certificate has be irector, page 2 sh	Completed						24a. Was a autop: perfor 1 \(\supersection\) Yes	SV	prior to co	psy findings available mpletion of cause of	
Vital	ysician: is certific director,	Be	25. Was case referred to medical examiner?	spital:			ce of Death (Chec					
<u> </u>	> .0 0	은	1 ☐ Yes 2 🖾 No Proceed to 1 ☐ Yes 2 🖾 No Proceed to 1 ☐ Yes 2 ☒ No Proceed to 1 ☐ Yes 2 ☐ Y	1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Other	_4 □ Nursing H	_		Other (Specify)	
Division of	Attending Physician: ar death. ector: After this certific by the funeral director.	Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year)	injury	M 1□1		28d. Describe ho				
>	74.50		4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	fy)	,		City or Town	n, State			
	the Hospital of this 24 hours a the Funeral D mpleted filled i	Medical	(Check 2 L Medical Examiner	an: To the best of my known: On the basis of examination Practioner: To the best of n	on and/or investi	gation, in my opinior	 death occurred a 	t the time, date an	nd place	e, and due to the ca	use(s) and manner stated.	
	To the with To the comment		29b. Signature and the of certifier	hen		29c. License	- / -	732	29d. Da	te signed (Month,	Day, Year)	
2	20		30. Name and address of person who com	pleted cause of death (Iter	m 23a) (Type, P	rint) 1	-		RD.	SILVER	SPRING, MD	
	Stat Registra		31. Date filed (Month, Day, Year) OCT 2 0 2009	82. Registrar's Sign	ture					209	110	

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		C	erti	ficate of	Death		Reg. No	200	9 35	191
	Physici	an	1. Decedent's Name (First, Middle, Las						2. Date of De Month	ath Da		3. Time of D	
	/Media		Richard	Allen			illiams		10	13		231	7 M
	Examir	ier	4a. Facility Name (If not institution, give	street and number)		4	b. City, Town, c	r Location of Death	C 1	40	County of Dear	_ *	
			Peninsula Page 6. Social Security Number 6. S	ex 7. Age (In yrs. i	last birthd	(av)	If Under Tyear	If Under 24 Hrs.	8. Date of Bir	th.	0 Bir	thplace (State or	Foreign
	Funeral Director			DAM 2□F 68	Yrs	W//	Months Days	Hours Min.	8-22-1	ıy, Year) (0	ryland	Torcigit
	land ow		10a. State 10b. County	10c. Cit	y, Town or	r Locat	ion					10d. Inside City	/ Limits
	Mary I-f sh	ţ	MD Wicomi	Fr	uitla	an d						1 □ Yes 2	2 📉 No
	n the	irec	10e. Street and Number		UILIA		10f. Zip Code			10g. C	itizen of What Co	untry?	
	th with	Funeral Director	111 Hayward Aven	ue			2	1826			USA		
	ems	ner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 1	13. Wa	s Decedent of H	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No)-	14. Race - Ame Black, White		
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Modical Examinar Lust by multiple at or other traumatic event, the "Modical Examinar Lust by multiple at	Completed by Fu	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 ሺ No If Yes, Give Year or Dates:			Yes 2X No	Specify:	, , , , , , , , , ,		Specify: Wh	,	
5	72 h "natu dical	ete	15. Decedent's Ed (Specify only highest gra	ucation de completed)	i (G	ive kin	nt's Usual Occup id of work done	during most of work	king	16b. i	Kind of Business	Industry	
2121	within iene. than	ם	Elementary/Secondary (0-12)	College (1-4or 5+)			NOT use retire	/			1	T daadaa a	
d 2	filed v Hygid	ပိ	17. Father's Name (First, Middle, Last)		Maii	itei	nance D	18. Mother's Nam	ne (First, Middle		ssisted	Living	
lan	ould be f Mental arked or atic eve	To B	George Was	shington	Will	lion	ne	Marv	Kathr		ับส	tchens	
Maryland	2 should and Men is marke	-	19a. Informant's Name/Relationship (1			and Number or Ru					
	1 and 2 Health a tem 27 is		Frances Williams	- Wife	111	Hav	yward A	venue, Fr	uitland	, Má	rvland	21826	
ore	es 1 g of He fitem r oth		20a. Method of Disposition	20b. P			on (Name of ory or other pla		Date		ocation - City or		
altimore,	t. Pa rtmer rtant:		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	Sha		int	Cemete	ry 10-2				, Maryla	nd
Ba	permi Depa Impor any ir		21. Signature of Function Service Ercent	1 la Carlein				n_Street			al Home	and 2190	/.
			23a. Part 1. Enter the disease, or comp	oli ations that caused the death							, maryra	Approximate	
	Physician		shock, or heart failure. List only	TOTAL CONTRACTOR OF THE PARTY O		Α.	^					Interval Betwee Onset and De	
	/Medical		disease or condition resulting in death)	a. Pu	uence of):		`				-		-
	Examiner		O-marking the Black are additional	Asthm	C								
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Liner Uniterping Cause (Disease or injury	Due to (or as a consequ	uence of):								
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C									
68760,	ficate be executed physician and s the burial-transit		Toodking in additive East	Due to (or as a consequ	uence or):								
387	ficate phys s the	Medical		.d									
Box (eath certifi attending p for use as	_	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	incy Ldeath	3□5	ctopic pregnanc				23d. Date of de	-	
.O.	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time of d 9 ☐ Unknown			ther (specify) _	·			Month	Day Ye	ear
Э.	s that jned t	by Pi	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the	e unde	rlying cause giv	en in Part I.	23e. Did t	obacco	use contribute to	the cause of dea	ath?
ğ	w requires been sign should be	ed k	Atnial f	bu: (lot)	vi				1 🗆	Yes 2	2 □ 1 00 3 □ P	robably 4□ Ur	nknown
Vital Records,	aw re as be 2 sho	Completed							24a. Was		24b. Were at	utopsy findings av	vailable
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/ita	hysician: The la nis certificate ha I director, page 2	Be (25. Was case referred to medical examiner?					26. Place of Dea					
of\	Physician: r this certific ral director, r	၉	1 Yes 2 No	Hospital: 1 Inpatient 2				4 LI Ruising n			6 □Other (Spe	cify)	
	ත <u>ම</u> ම	Certification:	27. Manner of Death 1	28a. Date of Injury (Month, Day, Year)	28b. Tim Injur		28c. Inju Wor M 1	ryat k? Yes 2 □ No	28d. Describe	how inju	iry occurred		
Division	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	rtific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm,	street	, factory, office		28f. Location (City or To			ural Route Numb	er,
	spital nours a neral D		29a. Certifier 1 Certifying Ph	ysician: To the best of my know	wledge, d	eath o	ccurred at the ti	me, date and place	, and due to the	cause(s) and manner a	s stated.	
	the Ho in 24 h the Fu	ledical	(Check only 2 Medical Examone)	niner: On the basis of examina and manner stated.	tion and/o	r inves	stigation, in my	opinion, death occu	rred at the time,	date ar	nd place, and due	to the cause(s)	
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier				29c. Licens		,		ate signed (Mon		
	8.	í	10 Evels	si			000	25674		10	116100		
	OBY			completed cause of death (Item	23a) (Typ	pe, Pri	nt)	25674 1~1~		A 1		21.	808
	Sta	l I	31. Date filed (Month, Day, Year)	32. Registrar's Signat	Y 6 ture	4	· D. U	inim	111.	ا شا	17641	y Mo	1
	રાટ Registr		OCT 19	2009 Januar	A.	10	arkal						

DHMH 17 Rev 1/2001

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amend #19h&6 of Maryland / Bepartment of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 8:00 p M 16 2009 John Zionkofski October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Hospital Elkton Cecil Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F Hours Min. 74 PA 174-26-3656 September 2, 1935 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County Hillsborough 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylal Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It will only on other traumatic event, It will be a process. 1 Yes 2 No Director Hillsborough Valrico-Valrico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 33594 **USA** 3508 Casey Jones Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Ves 2 □ No 1952-If Yes, Give Year or Dates 73 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify. ģ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Intelligence 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ <u>Anna Bershefski</u> John Zionkofski, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lorean Zionkofski/Wife 3508 Casey Jones Dr., Valrico, FL 33594 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) October 20, 2009 West Chester, PA R.A. Ferris & Co., Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Andrew G. Gee Funeral Home, 259 E. Main St., Elkton, MD 21921 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VE 20 ARDS Pres **Physician** R=50100 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical the ! use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ίς in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, β 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? performed' 25. Was case re erred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Inpatient 2 ER/Outpatient 3 DOA 1 | Yes 2 | 1 No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

12+1VA State Registrar

DHMH 17 Rev 1/2001

NAMITA

31. Date filed (Month, Day, Year)

DCT 2 0 2009

HOSPITAL

UNION

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State	State of	Maryland		rtment of F <i>tificate of</i> .		d Mental Hy	giene Reg. No. 2009	35163		
			Registrar 1. Decedent's Name (First, Mi	ddle, Last)					2. Date of De	ath	3. Time of Death		
	Physicia /Medic		Leola	А		A	nderson			1861 29 2009 0100 M			
	Examiner 4a. Facility Name (If not institution, give street and number) Season's Hospice						4b. City, Town, o Rand	r Location of De allsto		4c. County of De	^{ath} Ltimore		
-	Funeral Director		5. Social Security Number 177–32–4996		. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	rs. 8. Date of Bir n. (Month, Da 09 2	th 19, Year) 2 33	irthplace (State or Foreign Country) GA		
	land ow		Usual Residence of Decedent 10a. State 10b. Cour	nty	10c. City	, Town or Lo	cation				10d. Inside City Limits		
	a-f sh	ctor	MD	NA		Balti	more				1 X Yes 2 □ No		
	or 28	Dire	Number	2			10f. Zip Code	1015		10g. Citizen of What (
	eath w	Funeral Director	3831 Cottag	e Ave	ent Ever in II S	5 13)		1215	(Specify Yes or No		nerican Indian,		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Evantral must be notified at Once.	by	1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 ☐ Divorce	Armed Ford 1 Tes 2	es? XNo		fYes, specify Cuba I □Yes 2 X INo	an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	1			
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12	led with	Con	12th grade	na	,	Te	eacher a			City of Maiden Surname)	Baltimore_		
Baltimore, Maryland	d be fil ental H ced otl	Be C	17. Father's Name (First, Midd William Mit						Mae Day				
ary	should and Me s mark tumath	To	19a. Informant's Name/Relation			19b. Mailir	g Address (Street			er, City or Town, State	, Zip Code)		
Z	and 2 lealth m 27 is		John Jackso	n-Son					ltimore				
nore	ages 1 int of H t: If Ite / or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematic		ate 20b. Pl		sition (Name of natory or other place		Date	20c. Location - City of Pikesvi			
Ħ.	mit. Pa bartme bortani r injury		4 □ Donation 5 □ Other 21. Signature of Funeral Serv			22	d Ridge Name and Addre	ss of Facility	/6/09	PIKESVI.	ile, Md		
<u>~</u>	Der Der Der Der Der Der Der Der Der Der		× 1010me	a. Tho	mps	M 4	arch F/ 300 Wab	ash Av	e, Balt	imore, M	d 21215		
		0 10	23a. Part 1. ter the disease shock, o heart failure. I	, or complications that cal list only one cause on ea	used the death ch line.	. Do not ent	er the mode of dyi	ng, such as card	liac or respiratory a	rrest,	Approximate Interval Between Onset and Death		
-	Physician /Medical		Immediate Chrise (Final disease or condition resulting in death) Due to (or as a consequence of):										
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	ed sit	iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	ienno ut):									
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	eath certifica attending ph for use as th		IF FEMALE:	220 Hype oute	ome of progna	nov							
.O. Box	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1							23d. Date of d	Date of delivery Month Day Year		
rds, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant cond	ditions contributing to dea	th but not resu	ilting in the u	nderlying cause giv	en in Part I.		obacco use contribute Yes 2 ☐ No 3 ☐	to the cause of death? Probably 4 2 Unknown		
Division of Vital Records,	The law requate has been page 2 should	Completed							24a. Was auto perfo	psy prior t ormed? death	autopsy findings available to completion of cause of ?		
Vita	certific ector,	Be	25. Was case referred to med examiner?	Hospital:			. a Doa Oth	or:	eath (Check only o		1218 MAR		
ō	ding Phystolan: The In. After this certificate hat funeral director, page	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of	patient 2 Injury	28b. Time of	IL 3 LL DOA	4 🗀 Nursing	g Home 5 Resi	dence 6 Other show injury occurred	pectry) 070.3		
ion	ending eath. or: Afte	atio	Z L / tooldont	estigation	, Day, Year)	Injury		k? Yes 2 □ No					
Divis	al or Attences after death	Certification:		ald not be ermined 28e. Place of building	f Injury - At ho g, etc. <i>(Specif</i>)	me, farm, str	eet, factory, office		28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,		
	To the Hospital within 24 hours a To the Funeral completely filled	edical (29a. Certifier 1 Certi (Check only one) 2 Medi	fying Physician: To the bacal Examiner: On the baand manner	sis of examinat	wledge, deat tion and/or in	n occurred at the ti vestigation, in my	me, date and pl opinion, death o	ace, and due to the ccurred at the time,	cause(s) and manner date and place, and c	as stated. lue to the cause(s)		
	To the within 2 To the comple	Me	29b. Signature and title of cert	ifier AR +			29c. Licens			29d. Date signed (Mc			
	П		Melloh	ADM	ŋ		1145	6931		October	29 200)		
			30. Name and address of pers	an T B	of death (Item	23a) (Type, 5 40	Print) OCD C	orny RO	Randa	Ustown 1	29 200) 10		
	Sta Registr		31. Date fix 0 7 10 3 2	109 Seren	gistrar's Signat	ture	1	•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Gel ctoper /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FINNOL 1405pita 1+ DIM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In Vrs. last birthday) **Funeral** Year) Months Days Hours Min. 1 M & F Director 216-82-3819 07 12 65 MD 44 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatlh and Mental Hygiene. ant of Heatlh and Marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10a State 10d Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Madical Examiner must be notified at once. 1 X Yes 2 □ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1011 Webb Ct. 21202 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates: 1 ☐ Yes 2√☐ No Specify: Black Specify. 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2th grade Department Stores Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Cecil Gillis Carrie L Ballard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md 21202 Andre Arthur-Son 1011 Webb Ct, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Dorfation 5 □ Other (Specify) King Memorial Park 11/2/09 Woodlawn, Md 21. Signature of Funeral Service Licenses March F/H West trime 4300 wabash Ave, Baltimore, Md 21215 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shool, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** crdice Arrest /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last 12615 Examiner Due to (r as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transi 3reast attending physician and for use as the burial-tran Cancel Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate I performed? 2 D**X(V**o 1 Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 ☐ Pending investigation ieral Director: A 1 ☐ Yes 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital within 24 hours a 29a. Certifier tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar <1che

31. Date filed /MG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 25 AM ARGARET 2009 Medical 4a. Facility Name (if not institution, give street and number) MEDICAL 4b. City, Town, or Location of Death 4c. County of Death Examiner BAYVIEW HOPKINS BALTIMORE 8. Date of Birth (Month, Day, 7 – 20 – 1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🔀 F Director 74 218-32-5761 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No MD Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4801 Orville Avenue 21205 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: "natural", 3 X Widowed 4 Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ۵ Katherine O'Toole George Wise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is Charles E. Anders. Poplar Avenue, Baltimore, MD 21224 Sor 761.0. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State any injury or 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-2-09 Middle River, MD Hollv Hill 21. Signature of Filmeral S 22, Name and Address of Facility Bradley-Ashton FUneral Home Willow Spring Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Disease vears disease or condition Medical resulting in death) Examiner vears Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hsbestosis burial-transit The law requires that the death certificate be executed vears and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ξ Month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₫ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Division of Vital Records, Completed To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director; After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 🗆 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 M No ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certifier

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

4940 EASTERN AVENUE

29d. Date signed (Month, Day, Year)

BALTIMORE

2009

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9:50 AM ames 10 300 /Medical 4b. City, Town, or Location of Death
Baltimore 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner dical Ballimere Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**⊠**M 2□F Months Days Hours Min. 219-40-1433 65 **Director** 5/21/1944 We Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f show Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any Injury or other traumatic event, If a Mudical Evar, it at routh burndiffed at once. 1 ☐ Yes 2 ☐ No Director Baltimore Dundalk MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1604 Four George Ct. USA Funeral 21222 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Tyes 2 No UNK If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Commercial 12 <u>Estimater</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia Carter မှ Carl Bates 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) April White (Daughter 1604 Four George Ct., 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 10/09/09 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic 21. Signature of Ameral Service Licensee 22. Name and Address of Facility Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician bete disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events sequence of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions, if any leading the conditions, if any leading the conditions, if any leading the conditions, if any, leading to immediate cause of the conditions of the conditi Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) the 1 ☐ Yes 2 ☐ No 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 ? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To funeral 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No ours after death.

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filled in by the fu 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title

30. Name and address of person y

31. Date filed (Month, Day, Year)

NOV

Silia

completed cause of death (Item 23a) (Type, Print)

MY 32. Registrar's Signature 29c. License number NPI

29d. Date signed (Month, Day, Year)

2 Place Baltimore MM

09-08350 Roger Besaw

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

oger Besaw		For State	e of Maryland /		rtment of <i>tificate of</i>		and	Mental	Hygiene	Reg. No	20	09	3516
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Funeral Director	5	2/7 /2 0001			est birthday)	If Under Months		If Under 24 Hours	4Hrs. 8. Date of Min. 04/1	Birth(MN	W/DD/YYYY) 9. B	irthplace eign Country)	State or
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MD 2's should dith and Min 27 is man atic eaumatic eaumatic	<u>°</u> [19a. Informant's Name/Relationship Karen Besaw/Wi							rive, Co		city or Town, Sta	210	
Baltimore, ME permit. Pages 1 and 2 s Department of Health an Important: If item 27 injury or other traums	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Ardent Cremation Services 11/02/							Date 1/02/200					
Baltir permit. F Departme Importationjury or		21. Signature of Funeral Service Licensee Laura C. Handesty Morry 7522 Connulley Drive, Ste 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arm							Ste.	N, Hanov	er, l	MD 21076	
Physician /Medical		failure. List only one cause or					f dying, s	uch as card	diac or respiratory	arrest, s	shock, or heart		roximate Interval ween Onset and Death
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Division of Vital Records, na for Attending Physician: The law requirers after death. The Institute of the this certificate has been so an interference of the fineral director, page 2 should be the funeral director, page 2 should be a should be	Completed								f	utopsy performe res 2 ⊌	prior death	to comple	tion of cause of
Vital Rec	8	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	ent 2	ER/Outpatier			Nhan -	Nursing Home 5	Res	sidence 6 🗸 O	ther: Scer	e
ion of \text{tending Phy} eath. tor: After the funeral	1 V Yes 2 No 28a Detect Injury 28b Time of Injury 128c Injury at Work? 28d Describe how injury								injury occurred				
Division Hospital or Atti 24 hours after de Funeral Directorete stely filled in by t	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide 1 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									ute Number, City		
Di To the Hospital within 24 hours of To the Funeral completely filled	Medical C	29a. Certifier 1 Certifying Phy	rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)							se(s)			
and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E.								number		2	9d. Date signed October 29, 2	(Month, D	
		30. Name and address of person w	who completed cause of	death (Ite	m 23a)		0.0.1	vi.C.				~	·
		Ling Li, MD Assistan	t Medical Examine	er 11	1 Penn Stre	eet, Baltir	more, I	MD 2120	01				
Sta	ite	31. Date filed (New 17) Day Year)	Registra	ar's Signa	Te box	Res							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4:15 AM Physician/ Medical Eacility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Baltimore OWSON Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖭 F Min. Months Hours (Month, Dav. Year) Yrs. Director -20permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 HO im01 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced If Yes, Give Blac Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working /Seconday (0-12) life. DO NOT use retired) varage Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ nnsor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WASKILLS, 1-x ZIIIT Baltimore. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State SON Jimos Mills. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 61001 Marke 11cton, 23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, shock, or heart in are. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami physician and the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be attending phate as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 You No
9 Unknown Day 5 Other (specify) Pregnant at time of death theen signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy ge certificate 2 No Yes 1 Yes director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 **X**No 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural injury work? 1 🗌 Yes 5 Pending I Director: And in by the f 2 Accident
3 Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by 4 Homicide determined City or Town, State) To the Hospital or within 24 hours a To the Funeral D Medical 1 Z Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or inventigation is my calculated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles

State

Registrar

31. Date filed (Month, Day,

3 2009

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32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland State of Maryland Registrar	-	irtment of H <i>tificate of L</i>			ene 1. No.2	35169			
	Physici		1. Decedent's Name (First, Middle, Last) Charles Richard Badger				2. Date of Death Month	Day Year 200	3. Time of Death			
and the same of	/Medio		4a. Facility Name (If not institution, give street and number) Season's Hospice	• • • • • • • • • • • • • • • • • • • •	Location of Death	021000	4c. County of Dea	th				
	Funeral		5. Social Security Number 212-78-4891 6. Sex 1 □ X M 2 □ F 48	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Bir	thplace (State or Foreign ountry)			
	Director		Usual Residence of Decedent 10a. State 10b. County 10c. City, T		cation		11/19/1	960	D.C.			
:	a-f sho	Director	MD Baltimore	OWIT OF EOU		erstown			1 ☐ Yes 2 ☐ No			
3	23a or 24	al Dire	10e. Street and Number 654 Glynlee Court		10f. Zip Code	21136	10g	Citizen of What Co	ountry?			
036	orbusto de meu wiumin 72 hous arter deatri with the maryland. Montal Hygiene, marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show matic event, its Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates;		Vas Decedent of His Yes, specify Cubar □Yes 2⊠ No	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race · Ame Black, Whit				
Maryland 21215-0036	wumin 72 not ene. than "natura Majical F	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give I life. E		uring most of workii	ng 16	b. Kind of Business	/Industry			
nd 2	tal Hygie d other i	Be Co	N/A N/A 17. Father's Name (First, Middle, Last)			18. Mother's Name			N/A			
aryla	h and Men 7 is marker traumatic	욘		nkno			ia Ann I	Badger City or Town, State, .	Zip Code)			
e, K	Healt Healt Pm 2 ther		Danielle Mundie / provider 1	1431	Cronhill	Drive Su	ite C, O	wings Mil	ls, MD21117			
5	ment of tant. If it tant. If it jury or o		20a. Method of Disposition 1									
Bai	Department Important: If any injury or once.	4	21. Signature of Funeral Service Licensee porota Marsha		Name and Address	d Cremat	ion Ser	vices	ວດວ			
		N 1	23a. Partr. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final									
and the second	hysician /Medical xaminer		disease or condition resulting in death) a. Due to (or s a consequence)		allwe	-) [.					
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ng on f	ood 60	lus						
68760, tificate be executed	physician and s the burial-transit	cal Ex	resulting in death) Last Due to (or as a consequence of the consequen	ce of):		Card	etall	OL EXAMINER				
	00 00	/Medical	IF FEMALE: 23b. Was deceded progress 23c. If yes, outcome of pregnancy			CERTIFICATI	CHOUNT MET	AON				
P.O. BOX	by the atten ached for u	hysician/M	in the past 12 months?	4 ☐ Pregnant at time of death 5 ☐ Other (specify) Mon								
ords,		eted by P	Part II. Other significant conditions contributing to death but not resulting	g in the und	derlying cause giver	n in Part I.		oacco use contribute to the cause of death? es 2 □ No 3 □ Probably 4 █️️️️️Unknown				
r e	12 3	e Completed	25. Was case referred to medical				24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of 2 □ No			
T A	· ≅ ₽	원 ,	examiner? 1∰Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/		3 ☐ DOA Other		ne 5 Residenc	e 6 Mother (Spe	sayes Itorpia			
UIVISION I	ath. or: After he funera	ation	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28c. Injury at Work? 1 Yes 2 No Subject Chokelon Place of No. 1 Year									
DIVIS alor Att	s after de la Direct	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) CHANGE CT RURAL ROUTE NUMBER OF COUNTY OF COUN									
e Hospit	within 24 hours after death. To the Funeral Director. After t completely filled in by the funera	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	dge, death	occurred at the time	e, date and place, a	and due to the cau	se(s) and manner a	s stated			
70 Th	within To the comp	Me	29b. Signature and title of certifier		29c. License	number 5931	29d	Date signed (Mont				
		-	30. Name and address of person who completed cause of death (Item 23)	a) (Type, P	rint)		0.0.	CTOBOY	27 760)			
	Stat	e	31. Date filed (Month, Day, Year) 37 Fiegistrar's Signature	5401	OLI) CO	WILL KOST	U RITM	PALSTON	N MD			
	Registra	ır	NOV - 3 2009	A.	2							

	10.50		1 - For State Registrar	State of M	aryland / De		nt of Hea te of De		Mental Hy	giene Reg. No. 20	09	35170	
	Physici	ian	1. Decedent's Name (First, Middle, Las	t)					2. Date of De Month	Day	Year	3. Time of Death	
The same	/Medi	cal	Bruce Eugene	, Town, or Lo	10		009	6:00 a ^M					
Examine								WN	atri	4c. County	ningt	on	
	Funeral		5. Social Security Number 6. Se	7. Ag	e (In yrs. last birthd	y) If Und	er 1 Year If	Under 24 H			-		
	Director		213-40-0002	2 M 2□F	75 Yrs	Months	Days	Hours Mi		1933	Coun	lace (State or Foreign try) MD	
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					1	0d. Inside City Limits	
	Maryl	ğ	MD Was	hington		Wi.	Lliamsp	port				1 ☐ Yes 2 No	
	h the	Irec	10e. Street and Number		10f. Zip Code						Vhat Coun	ntry?	
	23a c	a D	8030 Avis Mill Ro			217	795			US	SA		
	hours after death with the Maryland tural', or Iteme 23a or 28a-f show at Examinational be notified at	by Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1	3. Was Dec If Yes, sp	edent of Hispa ecify Cuban, I	anic Origin? Mexican, Pu	(Specify Yes or No erto Rican, etc.)	14. Race Blac	e - Americ k, White,	an Indian, etc.	
36	I', or	by F	Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 次 tf Yes, Give Year or Dates:	No	1 🗆 Yes	21X No 3	Specify:		Specify	. Wh	nite	
5-0036	72 hou natura	ted	15. Decedent's Ed	ucation	16a. De	cedent's Us	ual Occupatio	n .		16b. Kind of Bu	siness/in	dustry	
21215	within 7 ene. then "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	de completed) Cottege (1-4or :	life	ive kind of w a. DO NOT	ork done duri use retired)	ng most of w	vorking				
	filed wi Hygien ther th		12			Labor	aborer			Feed 1			
and	ntal H ed otl	Be	17. Father's Name (First, Middle, Last) Omer Bruce Bowe	rs			18		's Name (First, Middle, Maiden Sumame) Bernice Elizabeth Fox				
Maryland	2 should the and Meni is marked burnatic and m	2	19a. Informant's Name/Relationship (T	vpe. Print)	19b. Ma	ailing Addres	s (Street and		Rural Route Numb				
S	nd 2 saith ar 27 is retreu		Yvonne Eyler / S			-			Williamsp				
J.e.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: if item 27 is marked other then "natural", or Iteme 23e or 28e-1 ehow with jolury or other treumatic event, the Mudical Examiliant rights be notified at ance.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ I	D	20b. Place of Dis	sposition (National Autory of	ame of other place)		Date	20c. Location -	City or To	wn, State	
Baltimore,	Pag ment ant: I		4 □Donation 5 □ Other (Specify,)	Final Jou	rney Cr	ematory		/31/09	Woodbi			
3alt	permit. Pag Department Important: any Injury o		21. Signature of Funeral Service Licens	Porota	Marshall	22. Name a			aryland (
	40 E # a		Jente a	s Mario	uau			Box 1	· - · · · · · · · · · · · · · · · · · ·	imore, N	של עווי	1203	
)	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of tmmediate Cause (Final disease or condition resulting in death)	a	rdior	esp	, Was	tory	Fan L	urest,	,	Approximate Interval Between Onset and Death	
	Examiner			Due to (or as a consequence of): Chronic Renal Failer							F	2122 411	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of): Chronic Oles Frieds we for Due to (or as a consequence of):						we Pullionary Severely			
	ecuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last										
760,	te be executed ysicien and ie burial-transit	cal Ex	Tosularing in double) East	Due to (or as	a consequence of):	4	Ma	16	1 00	seasa		Cappenly	
687	2 2 2			Di Seites Mexici					19	1 Jype II			
Box	The law requires that the death certificate to the law seem signed by the attending physicage 2 should be detached for use as the tops.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3 □Ectopic 5 □ Other (s				ellisa Severelly Casa Severely 23d. Date of delivery Month Day Year					
P.0	at the d	hys	9 Unknown	9☐ Unknown									
Records, I	w requires that been signed should be del	Completed by F	Part II. Other significant conditions co	Attur	ut not resulting in the	underlying						ne cause of death?	
3ec	The law rate has be page 2 sh	mple	Hype	rten	Sissa				24a. Was	psy p	rior to cor	psy findings available inpletion of cause of	
		e Co	05.14						1 ☐ Yes	200 No 1	leath?	2 □ No	
of Vital	Physician: this certificanal director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	int 2 ☐ ER/Outpai	ient 3 🗆 D	1000		eath <i>Check only</i> Home 5 Resi		- 10 - 1	,	
o	ding Phy th. After this funeral c		27. Manner of Death	28a. Date of Inju (Month, Da	ry 28b. Time	of	28c. Injury at Work?			how injury occurre		/)	
Sior	Mtendin death. ctor: Ali y the fur	atlo	1 Matural 5 Pending 2 Accident investigation	(World), Da	<i>y Yeer)</i> Injur	м		2 □ No					
Division	or Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At home, farm, c. (Specify)	street, facto	ry, office		28f. Location (City or To	Street and Numbe wn, State)	or Rura	l Route Number,	
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: Attercompletely filled in by the fune	Medical Co	29a. Certifier 1 Cartifying Phy (Check only one) 2 Madical Exami	sician: To the best iner: On the basis of and manner sta	examination and/or	eath occurre	d at the time, on, in my opinion	ce, and due to the curred at the time,	cause(s) and mai date and place, a	nner as si	ated. the cause(s)		
	To the vithin 2 To the comple	Med	29b. Signature and title of pertifier	and mainer Sta		25	c. License nu	ımber		29d. Date signed	l (Month,	Dey, Year)	
	->-0		DA Garla	M(1))354	197		10/30	/200	9	
			30. Name and address of person who co	ompleted cause of d	eath (Item 23a) (Typ	e, Print)		, /		.0/50	, _ 0 0	-	
		i i	Tanvir-Ahmad F	asha, M	.D.	11:	22 Opa:	l Cour	t Hager	stown, M	D 2'	1740	
	Sta Registr		31. Date filed (Month, Day, Year) 3 21	32. egistr	ar's Signature	Sass							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

illureu Sriaw D		State of Maryland / 1-For State Registrar	Certificate			Reg.	No. 2A	09 351				
Physici ledical Exami	an/	Decedent's Name (First, Middle,Last)				2. Date of Death Month D October 26,	ay Year	3. Time of Death				
iculcal Exami	HIGH	Mildred Shaw 4a. Facility Name (if not institution, give street and number)		Beck 4b. City, Town, or	Location of Death	October 26,	4c. County of Death					
		4228 Birch Avenue		Abingdon			Harford					
Funeral Director			(In yrs. last birthday)	If Under 1 Year Months Day		-	MM/DD/YYYY) 9. Bir Foreig	n				
Director		243-50-8120 1 M 2X F 7	7 Y	rs.		03 13	32 co	untry) NC				
any		10a. State 10b. County 10c. City, Town or Location 10d										
Aaryland 28a-f show any Lat once,	or	MD NA		1X Yes 2 No								
r 28a-	Director	10e. Street and Number		10f. Zip Code	215	10g.	Citizen of What Cou	1				
vith the s 23a o e notifi		2824 Boarman Ave 11. Marital Status 12. Was Decedent I	ver in U.S. 13. V	Vas Decedent of His		ecify Yes or No-		can Indian, Black,				
death v r items	Funeral	1 Never Married 2 X Married Armed Forces?	If No	Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	White, etc.					
after (ral", o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1_	Yes 2X No			Specify.	ack				
2 hours "natu		15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5	during	ent's Usual Occupa most of working life			6b. Kind of Business/	Industry				
036 ithin 7, ne. r than	Completed	12th grade na		Domestic			Priva	rivate				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygient and Prematural, it is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		17. Father's Name (First, Middle, Last)			18.Mother's Name	•						
212' uld be Mental marke event	To Be	Robert Jones 19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Stree		liza Po	er, City or Town, State	, Zip Code)				
MD d 2 sho lith and n 27 is		Horace James Beck-Husk		24 Boar	man Ave	, Balti	more, Mo	21215				
ore, s l and of Heal or tra		20a. Method of Disposition 1 X XBurial 2 Cremation 3 Removal from Sta		osition (Name of ce other place)	metery,	Date 2	20c. Location - City or					
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify:	Garrisc	n Fores		5/09	Owings M	Mills, Md				
Bal permit Depar Impo	(21. agnature of Funeral Service Licensee		larch Adres 1300 Wab	H'Wëst ash Ave	, Balti	imore, Mo	21215				
Physician		23a. Part I. Enter the disease, or complications that caused fallure. List only one cause on each line.	he death. Do not ente	r the mode of dying	, such as cardiac o	r respiratory arres	t, shock, or heart	Approximate Interval Between Onset and				
/Medical caminer	e W	Imm late Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease Death										
		or condition resulting in death) Due to (or as a conse Sequentially list conditions, b.	quence of):									
	iner	if any, leading to immediate Due to (or as a conse cause. Enter Underlying Cause	quence of):									
5	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
P.O. Box 68760, that the death certificate be executed ned by the attending physician and detached for use as the burial - transit		d.	brand brand									
60, ate be e hysician e burial	Wedical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome	e of preopancy				23d. Date of deliver	v				
687(ertifica ding ph		23b. Was decedent pregnant in the past 12 months?	2	Fetal death 3	Ectopic pregna	ncy		Day Year				
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 V Unknown 9 Unknown	ime of death 5	Other (Specify)								
P.O. Es that the can be detached		Part II. Other significant conditions contributing to death	but not resulting in th	e underlying cause	given in Part I.		acco use contribute to	r				
S, P.C uires that n signed	ed by					G		bably 4 Unknown				
cords, law requir has been s	Completed					24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of				
tal Rec cian: The l certificate l ector, page	Con	1			(5) (6)	1 Yes 2		es 2 No				
Vital hysician this certi	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatien	nt 2 ER/Outpatie		e of Death (Check		esidence 6 🗸 Othe	r: Scene				
Division of Vital Records, tal or Attending Physician: The law requires and edah. In Director: After this certificate has been sided in by the funeral director, page 2 should t		27. Manner of Death 28a. Date of Injur	ry 28b. Time o	of Injury 28c. Inju	ury at Work?	28d. Describe ho	w injury occurred					
ision Attendi rector: 2	atio	Natural 5 Pending 2 Accident Investigation			Yes 2 No			84 50 57				
Divis	Certification:	Suicide Could not be determined	ury - At home, farm, st	reet, factory, office	building, etc.	28f. Location (Str or Town, Sta		ural Route Number, City				
Division of Vital Records, P.O. Box 68760, within 24 bous after the death certificate be executed within 24 bous after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier (Check poly 1 Certifying Physician: To the best of my	knowledge, death oc	curred at the time, d	date and place, and	due to the cause((s) and manner as sta	ted.				
Fo the vithin To the complete	Medical	one) 2 Medical Examiner:On the basis of exam and manner stated.	nination and/or investi									
	Š	29b. Signature and title of certifier		29c. Licens	se number .M.E.		29d. Date signed (Month, Day, Year)					
		30. Name and address of person who completed cause of do	eath (Item 23c)		.IVI. L.		October 29, 200					
,		Ling Li, MD Assistant Medical Examiner		eet, Baltimore,	MD 21201							
	tate	31. Date filed (Nam Pay 37) 2009 3 Registrar	's Signature	Med								
Regis	urar		1									

Amend 7-9 per FH G897 11/6/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yea Physician 8 2009 11:15 AM /Medical County City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner macuda 192 Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1 M 2□ F Months 68 12/16/1941 Maryland Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar in ust be notified at MD Baltimore Baltimore 1 ☐ Yes ※☐ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21227 United States 3210 Hollins Ferry Road Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
14 Yes 2 □ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Baltimore City 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Allen William Balzanna ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5220 Wasena Ave., Baltimore, MD 21225 19a. Informant's Name/Relationship (Type. Print) Naomi Balzanna- Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Grave Run Cemetery 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State Grave 11-3-2009 Hampstead, MD 4 Donation 5 Other (Specify) -22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service License 2719 Hammond Fry Rd., Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NON Small Cell Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to minimodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a honsequence or; Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐No been signed by the should be detached 9 🗌 Unknown 9 🗀 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ca (Check only one) and manner stated within 2 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) D16354 OXI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGNES GOO CATON AVE BALT MD MARKO . Registrar's Signature 31. Date filed (Mor State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Month EDWARD **Physician** BOWENS TAMES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK VALLEY NURSING HOME WALKERSVILLE GLADE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day Aug 24 9. Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 Ø M 2 □ F Days 219-12-0233 MD. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at FREDERICK FREDERICK 1 Yes 2 No MD. Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō EDEN DRIVE 21701 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 1 1 1 1 2 1 No 11 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

TRUCK DRIVER MILLER CHEMICAL Elementary/Secondary (0-12) College (1-4or 5+) COM PANY TH h and Mental Hygie permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any lipiny or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM William LULA HARMON C. Bowens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1483 FDEN DRIVE FREDERICK MD 2701 19a. Informant's Name/Relationship (Type. Print) (DAU) SHIANN TALLEY 1483 BOEN DRIVE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State RESTHAUEN MOM. GM. NOV. 7, 2009 FALODERICA MD, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GARY L. ROWINS FUN. HUME 21. Signature of Funeral Service Licensee Rollin 110 WEST SOUTH ST AREOLAICH UND 21701 Bren d. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) **Physician** vears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of confifier 29c. License number 11-03-2009 050603 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) am (Item 23a) (Type, Print) 1475 Towey Ave Frederick, Md 21702 Trange CRUP Kathryn

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Resstrate Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, perFh 9897 11/3/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Bonilla November 2009 03:10 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockspring Village Forest Hill Harford Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛛 F 060-01-1138 D 90 Director June 16, 1919 | Puerto Rico Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Madical Era niner must be notified at 1 ☐ Yes 2X No Directo Maryland | Harford Forest Hill 10f. Zip Code 10g. Citizen of What Country? Street and Number 1 Colgate Drive 21050 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 ☐ No Specify: Puerto Rican Specify: Puerto Rican à 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, Ite Mente once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Uhknown ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Irma Maged (Daughter) 1821 Lear Ct. Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Raymond's Cemetery 11/6/2009 | Bronx, New York 21. Signature of Fugueral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services — Bel Air 3 Newport Drive , Forest Hill, Maryland 21050 23a. Parl/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat dailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardio-Pulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Advanced Age Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examine Dun to for as a consequence of The law requires that the death certificate be executed attending physician and for use as the burial-transit Hypertension Years resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) cate has been signed by the page 2 should be detached o 9 Unknown ت 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.
To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 sompletely filled in by the funeral director, page 2 sompletely filled in by the funeral director, page 2 sompletely filled in by the funeral director, page 2 sompletely filled in by the funeral director, page 2 sompletely filled in by the funeral director, page 2 sompletely filled in by the funeral director. autopsy performed 1 ∐Yes 2 🗷 No 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Time Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

10 1

Registrar NOV - 3 20

David McClure M.D. 31. Date filed (Month, Day, Year)

32. Registrar's Signature

615 MacPhail Rd. Bel= Air, MD 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** (+OBER 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Maryland 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Min 1 □ M 2 💢 F Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryls Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ira Medical Examiner must be notified at once. 1 ☐ Yes 2 No **Funeral Director** owson more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specity: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager 17. Father's Name (First, Middle, Last, Be 10# ဂ 19b. Mailing Address (Street and Number or Rural Route Number, 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place of Company of the place of Company of the place of Company of the place of the Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 Removal from State orest Hill MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and 21. Signature of Funeral Service Licensee tress of Facility Drk Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) mulocardial **Physician** /Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day 5 ☐ Other (specify) 9 Unknown 9 Unknowr 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗆 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 ✓ Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier

Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, certificate has been signed by the irector, page 2 should be detached this c After this funeral of n 24 hours after death.

ne Funeral Director: A
pletely filled in by the ft completely within 2 To the I

1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-00

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number se of death (Item 23a) (Type, Print) Charles Freet, Bathmore, 40 21212

State Registrar

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 30° **Physician** 2009 2:18 P M WILLIAM WALTER BARNES /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore County Baltimore 725 Murdock Road Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Hours Months Days 1**X** M 2□ F 70 Jan 23, 1939 Maryland Director 214-34-4236 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10b. County ir than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director Baltimore County Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 725 Murdock Road 21212 by Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 27 No 56-59 If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important; if item 27 is marked other the any Injury or other traumatic accept. Fleet Leasing Systems An<u>alyst</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leroy Lee Barnes Elizabeth Mary Strong 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 725 Murdock Road, Baltimore, Maryland 21212 (Wife) Mrs. J. Aleaisa Barnes 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dul. Valley Mem Grdns 11/4/2009 Timonium, Maryland 4 Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service License ²²MITCHELL-WIEDEFELD FUNERAL HOME Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of near failure. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ing physician and as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy Month Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of deaty Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 □ No 1 ☐Yes 2 ☐No Physician: 25. Was case referred medical examiner? 26. Place of Death (Check onl ne) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Mann of Death 28d. Describe how injury occurred 1 i Atural 2 Accident 5 Pending investigation To the Hospital or AttendIng within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hector Silva, MD, 7505 Osler Drive, Towson, Maryland 21204 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar Barket

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene rgiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 30, 2009 Robert Darvll Beauleau 7:05 A October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**⊠** M 2□ F Director 46 1963 055-58-7189 Feb. 6. New York Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Evanting rough by redffied at 1 XIYes 2 □ No Director Maryland Harford Aberdeen 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 601 Cornell St. 21001 USA Apt. 102 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 21215-0036 1 ☐ Yes 2X No Specify: Specify. ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Night Auditor Hotel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Pages 1 and 2 should be file train of Health and Mental H tant: If item 27 Is marked oth Be Vernon Junior Beauleau ပ Elizabeth (nmn) Ferrara 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stephanie M. Beauleau / Wife 601 Cornell St. Apt. 102, Aberdeen, MD 21001 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or c once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 4 ☐ Donation 5 ☐ Other (Specify) 11-4-09 Towson, Maryland 21. Signature of Juneral Service Licensee 22 Name and Address of Facility
MCComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, MD 21009 a Muc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PULMONARY Immediate Cause (Final disease or condition resulting in death) EMBOLISM . **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner Due to (or as a consequence of): 68760, Physician/Medical Box use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No o. detached 9 Unknown 9 I Unknown <u>ت</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>8</u> POST-ESOPHAGEAL CARGNOMA RESECTION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? ENAL TRANSPLACT 24a. Was an page 2 : autopsy performed? 1 Nes 2 No 1 ☐ Yes 2 ☐ No Vital within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To ō 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 > ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier en Nowolous uno

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDROW NOWAKOWSKY

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DO8096

35 FULFORD AVE BELAIR, MD 2014.

DOTOBER 30, 2009

amend #105 are 66 Margiand Department of Meanth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Maureen Lois Berman October 22, 2009 4:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Morningside House of Laurel Laurel Prince George If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 26, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral Months Days Hours Min. 1 □ M 2 🕅 F 77 1931 Connecticut Director 047-24-0997 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c, City, Town or Location 10d, Inside City Limits 10a. State show ir than "natural", or items 23a or 28a-f show the Medical Examinating the notified at Prince George's 1 √ Yes 2 No Director Laure 1 Spring MD 10g. Citizen of What Country? 7700 Cherry Lane ,Apt.3 10f. Zip Code 20707 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Department of Heath and Mental Hygien
Department of Heath and Mental Hygien
Important: If Item 27 is marked other the
any injury or other traumatic event, the Jones. Public High School Guidance Counselor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herman Shapiro Margaret Hassett မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alex Berman spouse 3152 Gracefield Rd. #124, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🗷 Removal from State Oct 25, 09 Middletown, CT Adath Israel 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee 313 Talbott Ave. Laurel, Maryland 20707-4389 M00773 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Alzheimer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physician and for use as the buri I-transit be xecuted resulting in death) Last Due to (or as a consequence of) Physician/Medical Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) 1 ∐Yes 2 🛛 No P.0. 9 Unknown 9 T Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Dysphagia Completed 24b. Were autopsy findings available prior to completion of cause of death? Failure to Thrive 24a. Was an cate has b page 2 s autopsy perform 2 **N**O 1 ☐ Yes 2 🖾 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: $_{4\,\square}$ Nursing Home $_{5\,\square}$ Residence $_{6\,\square}$ Other (Specify)Assisted 1 Yes 2 No this မှ 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Living To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 X Natural 5 ☐ Pending investigation nours after death, neral Director: Af y filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. 29b. Signature and the of certifier 53235 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

Registrar DHMH 17 Rev 1/2001

State

Darryl

31. Date filed (Month, Day, Year)

Hill, M.D.

NOV 0 3 2009

Registrar's Signature

13635 Baltimore Ave. Laurel, Maryland 20707

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 27, ANNA LUCILLE $a^{\ M}$ October 2009 7:00 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Patuxent River Nursing & Rehab. Ctr. Laurel Prince George's 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours 1 □ M 2 🖾 F Director 212-20-1597 85 May 21, 1924 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d, Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 🛛 No Director MD Prince George's Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6911 Brooklyn Bridge Road 20707 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or ite 1 ∐Yes 2 XXIX0 If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ∐Yes 2XXXVo Specify: þ Specify: 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12)
Grade 8 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Whitehead Viola Green ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trauonce. Brenda Fulton /daughter 6911 Brooklyn Bridge Rd. Laurel, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State John's Lutheran 10/30/2009 Ellicott City, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue M00770 Laurel, Maryland 20707 23a. Part 1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Arteriosclerotic Cardiovascular Disease over 1 year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, for the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical signed by the attending p d be detached for use as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Diabetes Mellitus cate has been signal by page 2 should by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXJnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2★★No 24a. Was an autopsy certificate **2X**XNo 2**X X**No 1 ☐ Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Khursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 **XXX**6 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1XXVatural Injury 1 ☐ Yes 2 ☐ No al or Attend after death 2 Accident the 3 Suicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a Hospital 29a. Certifier 1 🔀 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24721 October 28, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14333 Laurel Bowie Road, Suite 208 Syed Sadiq, M.D. Laurel, Maryland 31. Date filed (Month, Day, Year 32. Registrar's Signature State 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ma	ryianu / i	-	tificate of		vientai myt F	eg. N	2009	35	180				
	Physici	an	1. Decedent's Name (First, Middle, Las	st)					2. Date of Dea Month	th Day	Year	3. Time					
	/Medic				BUSCH				OCTOBER	29,	2009	9:45	5 A ^M				
	Examin	er	4a. Facility Name (If not institution, giv					r Location of Death		4c.	County of Death						
	Funeral		9543 DEVONWOOD CT 5. Social Security Number 6. S		(In yrs. last bir	rthdav)	ROSEDA If Under 1 Year	LE If Under 24 Hrs.	8. Date of Birth	1	BALT IMO 9. Birth	nplace (State untry)	e or Foreign				
	Director		216-16-4696	X M 2□ F 8		Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day AUG • 25	, Year)	24	intry) MD)				
	fand ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Loc	ation					10d. Inside	City Limits				
	a-f sh	ctor	MD BALTIM	ORE	ROSE	EDAL	E					1 □Ye	s 2 No				
	th the	Jire	10e. Street and Number				10f. Zip Code		1	-	zen of What Cou	intry?					
	ath wi	rall	9543 DEVONWOOD CT				21237			USA							
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if a firedical Eventius to indifine a once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ∑ Yes 2 □ No If Yes, Give Year or Dates:		.S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F			pecify Yes or No- Rican, etc.)	ecify Yes or No- Rican, etc.) 14. Race - Black, V Specify:							
5-0	72 hc	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a	(Give I	ent's Usual Occup	during most of work	ring	16b. Ki	nd of Business/li	ndustry					
121	within iene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) PC		OO NOT use retired E OFFICE			MD	STATE						
	filed Hygin	ပိ	17. Father's Name (First, Middle, Last)			льто	D OILION	18. Mother's Nam	e (First, Middle,								
lan	Aental rked o	To Be	GEORGE EDWARD BUS	CH, SR.				HELEN	CREMENS								
Maryland	:1 and 2 should Health and Mer tem 27 is marke other traumatic		19a. Informant's Name/Relationship (CARMELLA ANN BUSC				g Address (Street DEVONWOO	and Number or Ru D CT E	ral Route Numbe SALTIMORI	r, City o	r Town, State, Z	ip Code)					
Baltimore,	Pages 1 a ment of He ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				sition (Name of latory or other plac CREMATOR		Date 2/09		cation - City or T						
Balt	permit. Departr Importa any Inju		21. Signeture of Funeral Service Licen	see			Name and Addre	ss of Facility MII IR RD	LER-DIP				INC				
,	Physician /Medical Examiner	ledical Ex	ledical	Physician/Medical	Physician/Medical	Physician/Medical Ex	23a. Patt 1. Elter the disease, or composed of heart failural. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if a year of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence PS consequence consequence eum	of):	Syno	ng, such as cardiac		rest,		Approxim Interval B Onset an	etween
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit						IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome o	Petal death time of death	5 🗀	Ectopic pregnanc		23e Did to		23d. Date of deli Month	Day	Year
ds,	ires t signe d be c	d by	Dehidra	tion	not recalling in	i i io ui	donying baabb giv	or in t dit i.	23e. Did tobacco use contribute to the cause of do								
Division of Vital Records,	e law requires t has been signe ge 2 should be c	Completed by							24a. Was a autop perfor	SV	24b. Were aut prior to death?	topsy finding completion of	s available f cause of				
a	iclan: The certificate ector, pag		05 Massacrate and the office I						1 □ Yes	2 ☑No		2 □ No					
⋛	rsicla s cert lirectc	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	t 2 ☐ ER/Oι	utnation	Oth	er: A D Nursing H	th (Check only of ome 5 ☑ Resid		S DOthor (Case						
1 0	Attending Physician: or death. ector: After this certifici by the funeral director; p	n: T	27. Manno of Death	28a. Date of Injury	/ 28b.	Time of injury	28c. Injur	y at	28d. Describe h			пу)					
ö	ending Frath.	atio	1 atural 5 Pending 2 Accident investigation		rear)	injui y	M 1 🗆	Yes 2□No									
Divis	l or Att after de Directo	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.		ırm, stre	et, factory, office		28f. Location (S City or Tow		d Number or Ru)	ral Route Nu	umber,				
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of niner: On the basis of and manner state	examination ar	e, death nd/or inv	occurred at the tirestigation, in my c	me, date and place ppinion, death occu	, and due to the orred at the time, or	cause(s)) and manner as I place, and due	stated. to the cause	e(s)				
	To th withir To th comp	Me	29b. Signature and title of certifier	1 Man	_		29c. Licens	e number			te signed (Month						
			30. Name and address of person who	do (M)	ath (Item 23a)	(Type. F	Print) 705	D1617	THE D	116	12/20						
			FERNANDO DE	16ADD 1	NO		LIN	THICUM	1 ME	7	2106	10					
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 3 2000	Z. Registrar	's Signature	fa	w										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 31, 2009 Edward R. Calabrese 6:21 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 11007 Doxberry Circle Woodstock Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Jan. 20, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Year 1950 Connecticut 1**X**M 2□ F 041-44-9464 59 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County s 23a or 28a-f sho Maryland Howard 1 □ Yes 2 No Woodstock 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21163 11007 Doxberry Circle United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status event, the Medical Examiner Black, White, etc. ∐Yes 2 X No Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify Specify: þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer IT Architect 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Tyler Roland Calabrese item 27 is marke 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11007 Doxberry Circle Woodstock, Maryland 21163 Joyce Calabrese/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 2, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department or Important: If any Injury or once. <u></u> 5 Metro Crematory Baltimore, Maryland 2009 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee & Name and Address of Facility of Maryland, 299 Frederick Road Baltimore, Inc. Alice Iser Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** cancer months esophageal resulting in death) /Medical Due to k r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 □ Yes 1 ☐Yes funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ۵ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated.

State

Registrar

29b. Signature and title of certifier

30. Name and address of person who comple

Juergens

ed cause of death (Item 23a) (Type, Print)

orleans 32. Registrar's Signature

1650

29c. License number

Street Johns Hopkins

60203

29d. Date signed (Month, Day, Year)

CRET-693 Beltimore, Mary and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35182 Reg. NZ U 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 5:20P M 31, Lilly Belle Cronauer 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Riverview Care Center Essex Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1□M 3€7F Months Days Hours Min. 004-24-3796 07/21/1918 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Maryland Baltimore Essex 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 945 Renfrew Street 21221 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Stevens unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12209 Glenbauer Road, Kingsville, Maryland 21087 Date 20c. Location - City or Town, State Vaughn Cronauer (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc. 11/02/2009 Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Funeral Service Lansee 23a. Part1. Earer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dis 2 se or condition resulting in death) (or as a consequence of) Sequentially list conditions, π any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

Examiner the burial-transil and Division of Vital Records, P.O. Box 68760, ding physician signed by t To the Hospitel or Attending Physicien: funeral I Director: After to d in by the funera death.

Physician/Medical B within 24 hours a

To the Funeral C

completely filled Medical

Physician

/Medical

Examiner

Director

Funeral

Completed by

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Importent: if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Mouteal Examples any once.

Pnysician /Medical

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		pic pregnancy or (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	portributing to death but not resulting in the underly	ring cause given in Part I.		2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of
25. Was case referred to medical examiner? 1 □ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3[26. Place of Dead	performed? 1 ☐ Yes 2 ☐ N h (Check only one)	death?
27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	28c. Injury at Work?	ome 5 ☐ Residence 28d. Describe how inj	6 □Other (Specify) ury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier (Check only one) Certifying Physical Example 2 Medical sician: To the best of my knowledge, death occu iner: On the basis of examination and/or investig and manner stated.	rred at the time, date and place, ation, in my opinion, death occur	and due to the cause(red at the time, date at	s) and manner as stated. nd place, and due to the cause(s)	
29b. Signature and title of certifier)	29c. License number D-3875		ate signed (Month, Day, Year) 0-31-2009

MD- 21221.

State Registrar 709

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WASER

31. Date filed (Month, Day, Year)

P.O. Box 68760. Division of Vital Records. the Hospital or Attending hin 24 hours after death. To the Funeral Director: completely filled in by the within 24 hours

Registrar

4 Homicide

29a. Certifier

Medical

Bon Scrows Hospital 2000 W. Baltimore Street,

and manner stated

D0056240

29c. License number

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death - 29 ay - 200 ar **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Balhmore Ke Lev Wising Cen | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | 2-24-1918 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 □ M 2 🔀 F 216-05-8378 91 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it as Medical Examinar must be indiffied at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Completed by Funeral Director MD Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3320 Benson Avenue RM 344 21227 **USA** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1∐Yes 2**X** No Specify: white 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 education secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George John Ramming, Sr. Monica Elizabeth Miner ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Smith 2429 Saratoga Avenue Halethorpe, MD 21227 20c. Location - City or Town, State . Method of Disposition 20b. Place of Disposition (Name of A Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Opnation 5 ☐ Other (Specify)

Signature of Americal Service Liceosee Gardens of Faith Oct. 29,2009 Baltimore, MD 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line: Immediate Cause (Final disease or condition resulting in death) **Physician** men lears /Medical Due to (or as a consequence of): Examiner ems Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed ears VON attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. em 1 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, thri 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy perform this certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral or 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifiei and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2009 00 30. Name and address of person who completed leause of death (Item 23a) (Type, Print) MO 3320 enson 31. Date filed (Month, Day, Year) NOV 0 3 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 10 28 -ouise 09 9: 45p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Catonsville Under 1 Year | If Under Baltimore

9. Birthplace (State or Foreign Country) Charlestown Care Center Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months Min. 1 □ M 2 1 F Director 219-32-1935 6/24/35 Maryland 74 Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and: If item 27 is marked other than "natural", or items 23a or 28a-f show and: If item 27 is marked other than "natural", or items 23a or 28a-f show thy or other traumatic event, Ir. "No flot Exerciting remains to a refined a 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f shov officet Exeminer must be motified at 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 715 Maiden Choice Lane PV 506 21228 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DONo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) C & P Telephone Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kathryn Brite George Edward Trager 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Catonsville, Maryland 21228 6143 Regent Park Rd. Jane Aiello 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗖 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 10/30/09 Raltimore Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home Baltimore, Maryland 21229 3620 Wilkens Ave. 23a. Part 1. Enter the / isease, or complications, or hear value. List only ns that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) breast **Physician** static Cance /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any reading to initial discusse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to for as a consequence of Hospital or Attending Physician; The law requires that the death certificate be executed Exami and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No 5 ☐ Other (specify) io the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ፩ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 □Yes 2 ☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 1√10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 24 hours after death Funeral Director: 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 14437 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catonsville. Chaice Bowsli Deneen 32. Registrar's Signature 31. Date filed (Month, Day, Year) 0 3 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1:00 AM illiam Crawtord 2009 Movember /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Seasons Hospice Randallstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. July 27, 1939 9. Birthplace (State or Foreign 5. Social Security Number Sex XXM 2□ F 7. Age (In vrs. last birthdav) **Funeral** Months 70 216-36-9890 Maryland **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d Inside City Limits 10a State 10b. County 10c. City, Town or Location Is marked other than "natural", or items 23a or 28a-f show aumatic event, the "hedical Experience in ust be notified at Director 1 ☐ Yes XXNo Baltimore Ba1timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 U.S.A. 5400 Edmondson Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. 11. Marital Status XXYes 2 No lifes, Give 1957 Year or Dates: 1960 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes XXNo Specify: <u>Ş</u> 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Bendix Corp. Field Engineer permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If iten 27 is marked oth, any fillury or other traumatic event, otoe. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maria Cecilia Brink Albert John Crawford, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5400 Edmondson Ave. Baltimore, MD 21229 Thomas E. Crawford / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 11/7/09 Baltimore, MD 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Fysical Service Licensee 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** small cell /Medical Examiner Sequentially list conditions, if any, leading to infiniteliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) the burial-Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as 1 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate | 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 17/10 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 27. Manna of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Accident 1 □Yes 2 □No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 29a. Certifie 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifien

State Registrar

31. Date filed (Month, Day

japahx M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N (S ROID PAKSE, M.D 25 Mail) St.) Suite 200, Reisterstown, MD. 21136 Registrar's Signat

D0057465

For State Registrar

1. Decedent's Name (First, Middle, Last)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5, 10e, perFH, G901, 3/9, 2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month allender 17:32 M OCTOBER illiam 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death altmore althors Memoria MIDIO 214586¥6199 . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours Yrs Director baltimore, mu Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 23a or 28a-f show 10d. Inside City Limits d other than "natural", or items 23a or 28a-f sho event, the Medical Evaminer must be notified at 1 Yes 2 No Funeral Director MO inmore 19 figet and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 📉 No Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ovola College Popurities of the state of the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type. Print, 19b. Mailing Address (Street and Number on Rural Route Number, City Town, State, Zip Code) Keistarstown 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pl Date MBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specity) 3 🗁 R emoval from State Baltimore, mo Moreland Memoria f Furnish Service Lice 22. Name and Address of Fac eral chapel - Parkville Parkville, mo 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pulmonay Edema Due to (or as a confequence of): NBdays disease or condition resulting in death) /Medical Examiner End stage renal ~unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Diabetes mellitus 25 years Division of Vital Records, P.O. Box 68760, ounknown IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation r death. neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Dire 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Consider the control of the date and place and place and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) AT2438946 OCTOBER. 30, 2009 and address of person wato completed cause of death (Item 23a) (Type, Print) Union Memorial Hospital, Baltimore, MD Quianzon, MD. 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#4b.c.perPHYS, G897, 11, 3, 09, WS

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - State Registrar 35189 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2009 Month **Physician** 12:108 M Gerala haw 10 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore, land Mary University 3 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1**X** M 2□ F Months Days Hours Director 250-20-0968 85 July 26, 1924 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Examinar must be notilled at 1 ☐ Yes 2 ☐ No Directo Maryland Harford Aberdeer 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 337 Woodland Green Ct. 21001 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1▼JYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify \$ 3 Widowed 4 Divorced White Completed permit. Pages 1 and 2 should be filed within 72 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event any injury or other traumatic event and once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Helicopter Trainer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ George Elmer Cunningham Rose (nmn) Cereta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Betty Johnson Cunningham / 337 Woodland Green Ct., Aberdeen, Maryland 21001 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp: 11-3-09 Towson, Maryland Funeral rvice Licens McComas Funeral Home, P.A. Marle 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ruptured **Physician** Hortic disease or condition resulting in death) Horaccaldoninal /Medical Due to (or as a consequence of) Examiner alwose Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe this certificate 1 ☐ Yes 2 No 1 ☐ Yes or Attending Physician: ours after death.

eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DDS,MI Siavas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hessam Surgery Departmento Vascolor 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ruth Veronica October 30, 2009 3:30 A Cooper 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3001 Saint Clair Drive Harford Abingdon If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | Sept. | 28, 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | New Year | 1919 | 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 □XF 90 158-03-1867 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2√2 No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 USA 3001 Saint Clair Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes XXNo If Yes, Give Year or Dates: Specify Specify: 3 ☐Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. .DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Owner / Operator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edwin (nmn) Duncan Lillian (nmn) McCoy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Lillian Cohen</u> / daughter 3001 Saint Clair Drive, Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp.: 11-3-09 Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. Fun val Service Licensee te 1. Her 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHRONIC GOSTALOTIVE DULMONARY DISSASE Due to (or as a consequence of): HYDERPENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) CIRONIC REVAL INSUFFICIENCY Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No

Physician /Medical Examiner

Examiner

Physician/Medical

Completed

Be

Medical Certification: To

4 Homicide

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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12 should be filed with and Mental Hygier 7 Is marked other th

permit. Pages 1 and 2 st Department of Health an Important: If item 27 Is r any injury or other traun

Maryland 21215-0036

Baltimore.

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7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Examiner must be notified at

physician and s the burial-tran attending p signed by the a has page 2 this

Physician: The law requires that the death certificate be executed

P.0.

Division of Vital Records,

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☑No 9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital: Other: 4 ☐ Nursing Home 5 🛱 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

mp0058656

29c. License number

OCTOBER 30; 2004

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7505 OSLER DRIVE TUSON, MARYYMD 21204 MARK SALA MO

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 0 3 2008

After

or Attending

Hospital

To the

death.

within 24 hours after death To the Funeral Director: filled in by the

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State o	f Marylar	nd / Depa	artmen	t of H	lealth	and N	/lental Hy	gien	e 20	09	3519	1
			Registrar 1. Decedent's Name	e (First, Middle, Las			Cer	tificate	OIL	<i>peatn</i>		2. Date of De	Reg. N			3. Time of Death	_
	Physicia Medic		Agnes F	Colema	an							Octobe:		ay 200	Year 9	5:35PM	
	Examin		4a. Facility Name (if			ber)		4b. City, 7	Town, or	Location	of Death		4	c. County o	f Death		
	مر		Stella M	Maris Hos		7 1 1	t A b Seek A - A	T If Under	imon		0411				timo		_
1	Funeral Director		222-01-6	5465	M 2 X F	7. Age (In yrs. 9	4 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Nov • 4	th y, Year) 19	14	9. Birthp Count V1	lace (State or Foreign ry) rginia	
	nd thow at	្រុ	Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	ty, Town or Lo	cation								Od. Inside City Limits	-
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	th with ms 23 must	Funeral Director		oundwood 1					1093					USA		_	
р.ш. 36	permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	11. Marital Status1 Never Marri	ied 2 🗌 Married	12. Was Deced Armed For 1 Yes	ces? 2 🕅 No	H	Yes, speci	fy Cubar	n, Mexicar	n, Puerto	cify Yes or No- Rican, etc.)		14. Race Black	- America White, e		
$\overline{}$	ursafi tural", al Exa	ted	3 X Widowed		If Yes, Give Year or Da)	1	☐ Yes 2	X No	Specify	:			Specify:	Whi	te	
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			shock, or hear	ne disease, er comp t failure. List only o	cations that cane cause on each	aused the deat th line.	h. Do not ente	r the mode	of dying	, such as	cardiac c	r respiratory an	est,			Approximate Interval Between	
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Division	Attencr death	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not be determined	28e. Place o	of Injury - At ho	me, farm, stre	M et, factory,		fes 2□	-	28f. Location (S	treet ar	nd Number	or Rural F	Route Number.	_
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2	Certifying Phys Medical Examin K Certifying Nurs	ner: On the basis	s of examination	n and/or investi	oation, in m	v opinior	 death or 	courred at	the time date a	nd place	e and due to	the caus	se(s) and manner stated	d.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 Alonzo Messiao Carlton III 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Aberdeen 104 Riddle Drive 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8 Date of Birth Funeral Hours (Month, Day, Year) 2/27/1976 1 🕅 M 2 🗆 F Director 213 17 3975 33 Usual Residence of Decedent or items 23a or 28a-f show miner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Aberdeen Harford Maryland YYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21001 U.S.A. 301 Plaza Court, Apt 2A 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, injury or other traumatic event, the Medical Examiner Completed by 1 XNever Married 2 Married Specify Black 1 ☐ Yes 2X No Specify: 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Mental Hygiene. narked other than Elementary/Seconday (0-12) College (1-4 or 5+) At home 12 Disabled Be 18. Mother's Name (First, Middle, Maiden Surname)
Mabel Arlene Raisin 17. Father's Name (First, Middle, Last) marked be f Alonzo Messiao Carlton, Jr. permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mabel A. Carlton (mother) 301 Plaza Court, Apt 2A, Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Mt. Calvary Cemetery 10/31/2009 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
333 S. Parke St, Aberdeen, MD 21 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dyschythia Physician/ disease or condition I needed Medical resulting in death) Due to (or as a consequence of): Examiner Hunerleaden is Examiner if any leading to immediate cause. Enter Underlying End Stage Renal attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Yes 2 No 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 13 No within 24 hours after death.

To the Funeral Director: After this certificate ! 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital: Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the name (s) and market as stated Cartifying Nurse Fractioner: To the basis of my knowledge, death occurred at the time, date and dank and due to the name (s) and market as stated of the time, date and dark to the name (s) and market as stated of the time, date and due to the name (s) and market as stated of the time, date and dark to the name (s) and due to the name (s Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 000048050 10/27/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #YOU therdeen no 2001 Shukla MO 15 S. Parke Sta

State Registrar 31. Date filed (Month, Day, Year)

NOV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2009 2:39p M November Rosemarie C. Damas Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Centreville Queen Hospice of Queen Anne County 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Min. Feb. 8, 1922 Country)Germany Hours Director 87 368-40-3565 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director 1 🗌 Yes 2 🗌 No Maryland Queen Anne Grasonville 10e. Street and Number 10g. Citizen of What Country? Funeral 21638 United States 257 Prospect Bay Drive West items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 0. 1 ☐ Yes 2 🗓 No If Yes, Give Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", 3 X Widowed 4 . Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important If item 27 is marked other than any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grundmann Waldemar Johanna Krebs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 257 Prospect Bay Drive West, Grasonville, Maryland 21638 Michael J. Damas/ Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) November 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. Baltimore, Maryland 2009 Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician rebra disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 12/15/00 Sequentially list conditions, Examine as a consequence of If any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-translt Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Vascular disease IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death ed by the 9 Unknown P.O. | signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, mohoma Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 2 N death? certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Speci 1 🗌 Yes 2 **□**XNo ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifiei 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) e of death (Item 23a) (Type, Print) 30. Name and address of perser 8

State Registrar 31. Date filed (Month, Day, Year)

NOV 0 3 2009

32. Registrar's Signature

_			For State Registrar		State of Ma	ıryıand		epartmei Certifica					Reg. No	200	9	351	94
	Physicia	an	1. Decedent's Name (First, M								2.	Date of De Month	Da			3. Time of I	
3	/Medic	al	Ruby Arlene 4a. Facility Name (If not insti					4b. City	, Town, or	Location of	of Death	11	2 200 9 4c. County of Death			545	H "
	Examin Funeral Director		FRANKLIN Sc 5. Social Security Number 213–12–7565	6. Sex 1□	Hospita	1 Ce (In yrs. la 86	ast birtho	r f	205 e		24 Hrs 0	Date of Bir (Month, Da 1 / 24 / 1	th	9. Birthplace (State or Foreign Country) Maryland			Foreign
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	th with the 23a or 28a st be notif	al Director	10e. Street and Number 100 Franklin	Avenue	e, #1107				ip Code 1 221				10g. Cit	.A.	Country	/?	
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21215-0036	vithin 72 ho sne. fhan "natur e Medical l	Completed	(Specify only I		cation completed) College (1-4or 5	+)	(C	ecedent's Usi Give kind of w fe. DO NOT	ork done d use retired)	urina mos	t of working			and of Busine		stry	
9	filed v Hygie other 1		17. Father's Name (First, Mi	iddle, Last)			SCIIC	OI AIC	<u> </u>	18. Mothe	er's Name (F	irst, Middle			•		
<u>a</u>	lid be rked o	To Be	Clayton Black	ς.						Bert	ha Mi	ller					
Maryland	2 shou and N is mai		19a. Informant's Name/Rela		,			lailing Addres					-				
S.	l and lealth		Jeffrey Lee D	Davis	(Son)	20h P		North			Drive	•		re, Ma			221
200	ages 1 nt of H : If ite		1 Burial 2 □Crema		emoval from State	ł		isposition (Na crematory or Memo									
Baltimore,	Departme Mportani any injury		4 Donation 5 Oth 21. Signature 1 Full and Sci	1	ee] be.	LAL	22. Name a	and Addres	s of Eacili UZQZI	nski i	Funera	al H	ome, F	.A.		1 221
	452 6 6		23a. Part1 Enter the disease shock, or heart failure.	se, or compli	cations that caused	the death	. Do not							ex, Ma	11.	Approximate	9
	Physician /Medical		shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	. List only on	e cause on each lir Pneu Due to (or as	mo	nic									nterval Bet Onset and D	veen)eath
	Examiner				chron	\ C	069	struc	tive	Pu	Lmor	1914	d	iseas.	د		
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	• J °	Due to (or as												
3	ificate be executed g physician and as the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as	a consequ	ence of)	-							+		
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	tificate g phys as the	edical		-0													
O. Box	the death certy the attendin ched for use	Physician/M	IF FEMALE: 23b. Was decedent pregnal in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nt	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal	death	3 □Ectopic 5 □ Other (s						23d. Date o Month			Year
rds, P.	w requires that been signed by should be deta	þ	Part II. Other significant co	onditions cor	tributing to death b	ut not resu	alting in th	ne underlying	cause give	n in Part I	l.			use contribu 2.		cause of d	
or Vital Records,	has has	Completed										24a. Was auto perf 1□ Yes		prio dea	r to com	sy findings pletion of ca	available ause of
ital	ysician: Th is certificate director, pag	Be C	25. Was case referred to me examiner?	_			-			26. Place	e of Death (0			-1			
2		유	1 ☐ Yes 2 ☑ No	15	lospital: 1 Inpatie			atient 3 🗆 E		4 🗆 N				6 □Other (Specify)		
on (ding I	ion:		Pending nvestigation	28a. Date of Inju (Month, Da		28b. Tir Inju		28c. Injury Work	γαι ?? Yes 2		a. Describe	now inju	ury occurred			
Division	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	3 Suicide 6 □ C	Could not be determined	28e. Place of inj building, et			ı, street, facto				f. Location City or To		nd Number o	or Rural	Route Num	iber,
	n 24 hours re Funera letely filler	edical C			sician: To the best ner: On the basis o and manner st	f examina											3)
	To th within To th comp	Me	29b. Signature and title of c	certifier	\			2	9c. License					ate signed (A			
				> NAI					D631	054			No	/EMBER	- 2,	2000)
	/		30. Name and address of po		mpleted cause of d	eath (Item	ا 23a) (T	pe, Print) الإحمد	e Da	B	<IM-	o RE	M	212	57		
	Sta	te	31. Date filed (Month, Day	סחחפי	32. Registr	ar's Sina	ture	- Kal				,					
	Regist		MAN 03	LUUJ	coneur	14.	19"	- TI									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 Elizabeth Dowell 2009 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cherrywood Nursing Home Reisterstown Baltimore Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday 8. Date of Birth 1 □ M 2 🕟 F Months (Month, Day, Year) 78 Director 246-44-1221 Usual Residence of Decedent Dermit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Machine. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1 Yes 2X No Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Gwynnswood 21117 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 X Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry
Baby Clothing (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2th grade Seamstress Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James Edward Modlin Thadies Wiggins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keisha Dowell-Daughter Gwynnswood Road, Owings Mills, Md 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Melton Grove B.C. 11/7/09 Winfall, re of Funeral Service Licensee March for Figure t 4300 Wabash Ave, Baltimore, Md 21215 23a. Part i Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician/ Contesto disease or condition resulting in death) Medical Due to (or as a consequent Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): burial-transi that initiated events Due to (or as a consequence of). resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery n signed by the a Ild be detached f Part þ Completed has To Be 25. V

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 After this certificate Director: filled in by

hours after within 24 hours a

in the past 12 movins? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at time of death 5 Other (specify)		Month	Day	Year
II. Other significant condition	s contributing to death but fit resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute t		
	19 (len Suon	24a. Was an autopsy performed?	death?	completion	of cause of
Vas case referred to medical examiner?	26. Place of Death (Chec	ck only one)			
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing H	ome 5 Residence	6 Other (Spe	cify)	
Janna of Death	29a Data of injury 29h Time of ac 1				

27. N Natural (Month, Day, Year) iniury 5 Pending Accident Investigation Sulcide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,

29a. Certifier	1 Certifying Physician: To the bes	t of my knowledge, death occured at the time, date and place, and due to the c	ause(s) and manner as stated.								
(Check	2 Medical Examiner: On the basis	Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated									
only one)	only one) 3 Certifying Marse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature a	and title of certifier	29c. License number	29d Date signed (Month, Day Year)								

30. Name and son who comple 29d. Date signed (Month, Day, Year)

31. Date filed (Month

State Registrar

Certificate:

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8 & 18 per EH g897 11/5/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Month **Physician** 0809 ам October 26, PEGGY ANN DORSEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Montgomery Silver Spring, Maryland Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1940 9. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F October 10, 2009 Washington, DC 69 577-56-3948 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r than "natural", or items 23a or 28a-f short the Wedical Evaminer must be notified at 1 X Yes 2 □ No Director DC Washington, DC with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20018 USA 3308 18th Street, NE Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 Married Specify: Black altimore, Maryland 21215-0036 by If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir. Department of Health and Mental Hygien. Important: If item 27 is marked other the any injury or other traumatic event, the once. 12th Medical Transcriptionist Private years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Whitaker Clara Jones Whitaker ဂ Henry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Larry Dorsey - Husband 3308 18th Street, NE, Washington, DC 20018 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial, 2 ☐ Cremation 3 ☐ Removal from State 10/31/2009 Suitland, Maryland Washington National 4 □ Dona on 5 □ Other (Specify) 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funeral Service Licensee 716 Kennedy Street, NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Renal Failure, Hyperkalemia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Metastatic Sarcoma resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 💆 No 23d. Date of delivery 3 🗆 Ectopic pregnancy 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🛣 No 1 □ Yes 2 X No 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0063639

Registrar DHMH 17 Rev 1/2001

State

1500 Forest Glen Road, Silver Spring, Maryland 20910

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bergit Schoellman, MD,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Depart		/lental Hygi	ene	35197
		Registrar 1. Decedent's Name (First, Middle, Last)	ificate of Death	Re 2. Date of Death	g. No 2009	
Physicia		Anthony Peter D'Antoni		Month October	30°, 2009	3. Time of Death 5:35 A. M
Medi Examir			4b. City, Town, or Location of Death	Joesoner	4c. County of Death	2.32 11.
- P		Gilchrist Hospice Care	Towson		Baltimor	е
Funeral Director		5. Social Security Number $\begin{array}{c} 6. \text{ Sex} \\ 1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ $	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Feb. 10,	^{'ear)} 928 Mary	ace (State or Foreign
		Usual Residence of Decedent		reb. 10,	1920 [Haiy	tanu
yland •f sho ed at	ctor	10a. State 10b. County 10c. City, Town or Local	tion		10	0d. Inside City Limits
e Mar r 28a	Director	Maryland Baltimore Towson 10e. Street and Number	10f. Zip Code		Olai- on of Milato	1 Yes 2 No
with the 23a c	eral	19 Bellows Ct.	21204	10	g. Citizen of What Count U.S.A.	rry?
Jeath Jitems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - America	
36 after o	l by	1 Never Married 2 A Married 1 1 Yes 2 No	Yes 2 🕅 No Specify:	nican, etc.)	Black, White, e	
within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at	Completed	Year or Dates.1940-47	ent's Usual Occupation	- 14	6b. Kind of Business Ind	
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Ind 21215-0036 a filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	lοl	12 years True	ck Driver		Oil Compa	ny
land be filed ental Hy ked oth	To B	17. Father's Name (First, Middle, Last) Vincent D'Antoni		e (First, Middle, Ma D [†] A	,	
farylan should be fil and Mental is marked raumatic ev			Rosina Address (Street and Number or Rura			ode)
id 2 sh alth a n 27 is		1		n, Maryla		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Example.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposicemetery, cremation 3 ☐ Removal from State	tion (Name of atory or other place)	Date 2	0c. Location - City or Tov	wn, State
Itim it. Pag rtmen rtant njury		1 Burial 2 To Cremation 3 Removal from State 4 Donation 5 Other (Specify) Green Mour	nt Crematory 11-3	3-09 E	Baltimore, M	Maryland
Baltimore, I permit. Page 1 and Department of Heal Important: If item 2 any injury or other once.	92	21. Signature of Funeral Service Licensee 22. Mr. Mr.	Name and Address of Facility itchell-Wiedefeld 5500 York Road B	l Funeral Baltimore	Home, Inc.	21212
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac c	or respiratory arrest	t,	Approximate Interval Between
~ Physician/ Medical	177	Immediate Cause (Final disease or condition resulting in death)	ephropathy		4	Onset and Death
Examiner		Wile to (or as a consequence of):	, 0 /		1 /	scare !
	iner	Sequentially list conditions, b. Due to (or as a consequence of).				
cuted nd transit	xam	cause. Enter Underlying Cause (Disease or iinjury that initiated events o				
60 ate be executed hysician and the burial-transit	dical Examiner	resulting in death) Last Due to (or as a consequence of):				
760 icate b i physic		d				
ox 6876 eath certificat attending ph	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	Ectopic pregnancy		23d. Date of deliver	y
Box e death c the atten	Physician/Me		Other (specify)		Month (Day Year
S, P.O. Bc	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did toba	cco use contribute to the	e cause of death?
IS, Fullines the sign of sign of the sign	ed by			1 🗆 Yes	2 No 3 □ Prob	ably 4 🗆 Unknown
w requires been so shou	plet			24a. Was an		sy findings available
Rec The la	Completed			autopsy perform 1 Yes 2		pletion of cause of
ital ician: sertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check	(only one)		
Phys Phys	은 ::	1 Inpatient 2 ER/Outpatient 27. Manner of Dewin 28a. Date of injury 28b. Time of	3 ☐ DOA ☐ 4 ☐ Nursing Ho	me 5 Residence 28d. Describe how	ce 6 Other (Specify)	nospice
on C anding ath. r: Afte	icat	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	work? M 1 ☐ Yes 2 ☐ No	Edd. Doodilbe flow	injury occurred	
Division of Vital Records, tal or Attending Physician: The law requires rs after chath. al Director: After this certificate has been signed in by the funeral director, page 2 should be	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural F State)	Route Number,
pital o		200 Codifice Codificing Physician To the boot of my knowledge doubt a good of	aured at the time data and allow			
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check check only one) Certifying Physician: To the best of my knowledge, death occurrence on the basis of examination and/or investigned only one) Certifying Nurse Practioner: To the best of my knowledge, death occurrence only one)	ation, in my opinion, death occurred at	the time, date and	place, and due to the caus	se(s) and manner stated.
Vithi Vithi To the		29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Da	ay, Year)
		· Janams	D 58303	0	croser 30	2009
		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	es ST touson	MO		
Sta	te	31. Date filed (Month, Day, Year) NOV U 3 2009 32 Registrar's Signature And Andrew Month, Day, Year)	50 32	7701)		
Registr	ar	NOV 0 3 2009 Brewn B. Jan	Ked			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland	/ Depa <i>Cer</i> i	rtment of F	lealth and <i>Death</i>		giene 0 C	9 35198
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last, A. £/\(\frac{1}{2}\) \(\frac{1}{2}\) \(\frac{1}\) \(\frac{1}{2}\) \(\frac{1}{2}\) \(\frac{1}{2}\) \(V Dulan		4b. City, Town, o	or Location of Dea	2. Date of De Month	Day	Year 3. Time of Death Year 1 1 1 M Ol Death
	Funeral Director		5. Social Security Number 6. Sec 214-17-6201	Hospital	t birthday) Yrs.	If Under 1 Year Months Days	d ~ 1 6 t If Under 24 Hrs Hours Min		iy, Year)	9. Birthplace (State or Foreign Country) Maryland
	e Maryland la-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Aru	,	fown or Loc ton	ation				10d. Inside City Limits 1 ☐ Yes 2X No
	h with th	al Directo	10e. Street and Number 1523 Lowell Ct.			10f. Zip Code 21114			10g. Citizen of W	What Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Manial Hygiene. Important: If item 27 is marked other then "neture!, or iteme 23e or 28e-f ehow enty injury or other traumatic event, it a Madical Exacting ranal & rotified at ance.	by Funeral		12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If	as Decedent of H	dispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		
Maryland 21215-0036	within 72 ho ene. then "netur the Medical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give k life. D	O NOT use retire	during most of wa	rking	16b. Kind of Bu	
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lary	2 should and Me is mark sumation	P P	John Eugene Wilso 19a. Informant's Name/Relationship (Ty		19b. Mailing	Address (Street	and Number or R	en A. Ca ural Route Numb		State, Zip Code)
ore, N	of Heelth item 27		Everett Dugan / Hu 20a. Method of Disposition	20b. Plac	6219 e of Disposi etery, cremi	58th . ition (Name of atory or other place		iverdale Date	<u> </u>	0737 City or Town, State
Baltimore,	nit. Page artment o ortant: If injury or		1 ☐ Burial 2 【☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Func. Service Literas	Metr	o Crer	natory Name and Addre	Nov.	2, 2009	Catonsvi	11e, Maryland
Ba	Depa Impo eny is		1 April	7	Ki:	rkley-Ru L Crain	ddick Fu Hwy. SE;	Glen B	urnie, M	ID 21061
	Physician /Medical		23a. Pan1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	inf	eret;	12	•		Approximate Interval Between Onset and Death
8760, H	ate be executed Whysician and the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (br as a consequen	ono Z	ie (e)	4,019	ryler	direc	3): 62
P.O. Box 6	uires that the death certifica signed by the attending ph d be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3 E	ectopic pregnancy Other (specify)	,		23d. Date Mon	e ol delivery hth Day Year
rds, P.	w requires that is been signed by		Part II. Other significant conditions con	itributing to death but not resulting	ng in the und	derlying cause giv	en in Part I.			ibute to the cause of death? 3 Probably 4 Donknown
al Recc	n: The law re icete has be r, page 2 sho	Completed	Ful stept	of Rough	di	repe	and the second s		osy pormed? d	Vere autopsy findings available rior to completion of cause of eath? □ Yes 2□ No
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Attenthis certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Othatural 5 Pending investigation	ospital: 1 Inpatient 2 ER 28a. Date of Injury (Month, Day Year) 28	/Outpatient b. Time of Injury	28c. Injur Wor	er: 4 □ Nursing H	T	one) dence 6 Othe how injury occurre	
Divis	al or Atte s after de al Directo ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, larm, stree	et, factory, office		281. Location (; City or Tox		er or Rural Roule Number,
	e Hospital or 124 hours atte e Funeral Dir letely filled in	edical (29a. Certifier 1	sician: To the best of my knowle ner: On the basis of examination and manner stated.	dge, death of and/or inve	occurred at the tirestigation, in my o	ne, date and place pinion, death occi	e, and due to the urred at the time.	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
	To the within 2 To the Complet	Ň	29b. Signature and title of certifier	H/Sibh/		29c. Licens	e number 974		-	(Month, Day, Year)
	3		30. Name and ddress of person who co			rint)				7 30
	Sta Registr		Alice Hseih M.D. 31. Date filed (Month, Day, Year) NOV 0 3 2009	32. Registrar's Signature		.; Balt	imore, M	ID 21133)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			_ FOF	State of Maryla				d Mental Hy	giene	
			State Registrar		Ce	rtificate of	Death		Reg. No. 2 0 0	35199
	Physici	an	1. Decedent's Name (First, Middle, Last)	1 3				2. Date of Dea Month	Day Ye	
and the same	/Media	cal	4a. Facility Name (If not institution, give str	inard LD	enger	4b. City, Town, o	or Location of De	eath //	4c. County of D	9 7:45 A M
	Examin	ier	Balton a Rolalite	F F. x al	C-2-0	Bald	more	Jaur	N/A	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yr.	s. last birthday)	If Under 1 Year Months Days	If Under 24 h	lin. 8. Date of Birt	th 9.	Birthplace (State or Foreign Country)
н	Director		220-30-3039	^{1 2□} F 60	Yrs.	Months Days	Hours IV			ARYLAND
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits
	Maryli f sho	ō	MARYLAND N/A		BALTIMO					1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number		DILLITIO	10f, Zip Code			10g. Citizen of What	Country?
	th witi		5565 CEDONIA AVENU	E		212	06		U.S.A.	
	r dea	Funeral	11. Marital Status	. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of I	Hispanic Origin? an, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	- 14. Race - A Black, W	merican Indian, hite, etc.
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed ধ 🗘 Divorced	f XX Yes 2 ☐ No If Yes, Give Year or Dates:		1 □Yes 2√TNo	Specify:		Specify:	WHITE
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Examiner must be rodified at	ted	15. Decedent's Educa	tion	16a. Dece	dent's Usual Occu	pation		16b. Kind of Busine	
215	hin 72 e. an "na	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of (d)	working		
	flled within Hygiene. other than "	ပ္ပ	12TH. GRADE		PR	INTER	T .		GRAPHIC	ARTS
Maryland	s should be filed wand Mental Hygies marked other taumatic event, In	B	17. Father's Name (First, Middle, Last) GEORGE LEONAR	n 1	DOENGES			Name (First, Middle,	•	MET AZOUTOZ
ξ	hould d Me mark matic	오	19a, Informant's Name/Relationship (Type			na Address (Stree	MARY		NNA er, City or Town, Stat	TELAKOWICZ
	nd 2 shoulth and 27 is ma		NANCY GOLDSMITH/SI	,	-	REEN WIN			EYS ISLAND	
ře,	ges 1 and 2 should be filed within 72 hours after death with the Marylan tt of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, true Medical Examiner must be notified at	2	20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Location - City	or Town, State
Ë	Pa ant ury		1 ☐ Burial 2 XX cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval from State AT:	•	CREMATOR		2/2009	GLEN BURN	IE MD
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other th		21. Signature of Funeral Service Licenses		22	2. Name and Addr MILLER-D	ess of Facility	UNERAL HO	ME, INC.	
=	90 E 8 9		10 m/g		-	6415 BEL	AIR ROAL	D BALTIM	ORE MD 212	
			23a. Part 1. Enter the disease, complications, or heart failure. List only one immediate Cause (Fin.	cause on each line.	alla Liu not en	er the mode of dy	ng, such as care	diac or respiratory a	rrest,	Approximate Interval Between Onset and Death
and the same	Physician /Medical		disease or condition resulting in death)	Carcinon	na of	Kect	om_			unknows
7	Examiner			Due to (or as a conse	equence of					
	p +	ner	Sequentially list conditions, if any, leading to immediate cause. Cluse (Disease or injury that initiated events.	Due to (or as a conse	equence of):					
	xecuter and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
8760,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a conse	equence of):					
687		edical	d. ,							
Box (eath certific aftending p	Ž	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of preg					23d. Date of	delivery
	death	icia	in the past 12 months? 1 □Yes 2 □No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		☐ Ectopic pregnan ☐ Other <i>(specify)</i> _	су		Month	Day Year
P.0	at the by the	Physician/M	9 🗆 Unknown							
	The law requires that the death certificate has been signed by the affending I page 2 should be detached for use as		Part II. Other significant conditions contri	ibuting to death but not re	esulting in the u	nderlying cause gi	ven in Part I.	23e. Did t		e to the cause of death? Probably 4 Unknown
Records,	w requir been s should	Completed by						-		
Rec	has law	ם				.		— 24a. Was autor	an 24b. Were prior med deat	e autopsy findings available to completion of cause of n?
Vital	in: The lifticate or, par		25. Was case referred to medical				26 Place of I	1 ☐ Yes Death (Check only o		/es 2□No
Ž	ysicitalis cert	o Be	examiner? /	spital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Ot	nor.		dence 6 Other (5	Specify)
u of	or Attending Physician: The I after death. Director: After this certificate ha in by the funeral director, page	Certification: To	27. Manuer of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o	f 28c. Inju	ry at	1	now injury occurred	
Sio	tendii eath. or: A the fu	catic	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No			
Division	il or Attend after death Director: J	ığı,	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str <i>cify)</i>	eet, factory, office		28f. Location (3 City or To	Street and Number of vn, State)	r Rural Route Number,
Ц	spital ours a heral I		29a. Certifier 1 Certifying Physic	cian: To the best of my ki	nowledge, deat	h occurred at the t	ime, date and p	lace, and due to the	cause(s) and manne	er as stated.
41	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical		r: On the basis of examinand manner stated.						
	To the Hospital within 24 hours a To the Funeral I completely filled	Me	29b. Signature and title of certifier	1		29c. Licen			29d. Date signed (M	onth, Day, Year)
			\$ 6	I how	<i>y</i> .	34	359(0	H10)	111	09
			30. Name and address of person who com	pleted cause of death (Ite	em 23a) (Type,	Print)	O.B.	HIO)	1 1	. 0-
	C.	•	31. Date filed (Month, Day, Year)	32. Registrar's Sign	<i>ใจน 1504 .</i> nature	evard, 13	alTimora	1 Maryle	ind 212	18
	Sta Registr		NOV 0 3 2008	A	A 6	edd				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Day **Physician** Marie Charlotte Evans October 28. 2009 9:24 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7860 St. Claire Lane Dunda1k Baltimore If Under 1 Year | If Under 24 Hrs. Months Davs Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 😿 F Director 93 July 28,1916 214-68-0446 Pennsylvania Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f show event, the involcal Evamination and MD Baltimore Dundalk 1 ☐ Yes 21 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7860 St. Claire Lane 21222 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 is marked other than "natural", or iten 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€No Specify <u>\$</u> Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Scott S. Gailbraith Helen M. Isenberg ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7860 St. Claire Lane Dundalk, Maryland 21222 Nadine Sufczynski (Daughter) Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any Injury or ot ₩ Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specity) -11/4/2009 Bel Air Mem. Gdns. Bel Air, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of eral Service 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STENDSIS AORTIC **Physician** YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 X No 1 □ Yes 2 Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of al or Attending P s after death. I Director: After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide 29a, Certifier Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

P.0. Division of Vital Records, within 24 hours a

To the Funeral I

completely filled

> State Registrar

29b. Signature and title of

31. Date filed (Month, Day,

ROY ZIEGELSTEIN

29c. License number D38461 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

M.D. JOHNSHOPKINS BAYVIEW; 4940 EXSTERN AVE;
Registrar's Signature

BALTIMORE, MD ROY ZIEGELSTEIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** Mary I. Freeburger Sept 30 2009 9:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Overlea Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🗓 F Hours **Director** 19, 1922 <u>216-16-2578</u> Maryland Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Evantiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6116 Belair Road 21206 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1∐Yes 2∏No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Huck Wilkinson Gracey Helen Gildensenny 19a Informant's Name/Relationship (Type Print)
Department of Aging
M. Lucas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N. Calvert Street, Baltimore, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct. 5, 2009 Baltimore, MD Moreland Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Skarda Funeral Home Momas 2829 Hudson Street, Baltimore, MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Dementia /Medical Due to (or as a consequence of) **Examiner** Progressive Decline Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) the death certificate be executed burial-transi Exam Hypotension and Due to (or as a consequence of) attending physician Physician/Medical Endocarditis as the IF FEMALE: use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy ō in the past 12 months? Month Day Year signed by the a d be detached fo 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown speen s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page ; certificate 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

O. Box 68760, σ. Division of Vital Records, or Attending Physician: To the Hosping. .. within 24 hours after death.
To the Funeral Director: Aft

29a. Certifier (Check only one)	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)												
29b. Signature and	title of certifier	29c. License number	29d. Date signed (Month, Day, Year)										
•	1	D31464	October 1, 2009										
30. Name and addr	ess of person who completed cause of death (Item 23a) (Type, Print)												

State Registrar

Medical

Shoaib A. Hashmi, MD 821 N. Eutaw St. Suite 308, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of M	aryland		artment of F rtificate of I				2000	35202		
			Registrar 1. Decedent's Name (First, Mide	die, Last)			timoate or i	Douin	Date of Deat	th		3. Time of Death		
	Physici /Medio		Sue Carol	Frangowlakis					Novembe i	$r \stackrel{Day}{1}$	2009	12:44 A ^M		
A. A.	Examir		4a. Facility Name (If not instituti	on, give street and number))			Location of Deat	h	4c. County of Death				
	Funeral		Union Hospita 5. Social Security Number		ge (In vrs. la	ast birthday)	Elkton If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		ecil 9. Birthp	lace (State or Foreign		
E	Director		220-32-3576	1 □ M 2 💢 F	71	Yrs.	Months Days	Hours Min.	(Month, Day, 2/18/19	Year)	Mary	itry)		
	and w		Usual Residence of Decedent 10a. State 10b. Count	tv	10c. City	, Town or Lo	cation				1	0d. Inside City Limits		
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	th the	Director	10e. Street and Number				10f. Zip Code		1	-	n of What Coun	try?		
	ath wil		700 West Bela				21001				S.A.			
980	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Madeal Extruitment out the Indiffied at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	If Yes Give	>		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🛣 No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- to Rican, etc.)		. Race - Americ Black, White, e pecify: Whi	etc.		
Baltimore, Maryland 21215-0036	n 72 hou "natura	Completed	(Specify only high	ent's Education nest grade completed)		16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wor	king	16b. Kind	of Business/Inc	dustry		
212	d withii giene. rr than	omo	Elementary/Secondary (0-12)	College (1-4or s	5+)		memaker	"						
9	be filed tal Hy d othe event,	Be C	17. Father's Name (First, Middle						ne (First, Middle, I		ırname)			
Z∃a	should be fand Mental s marked o	은	Robert	L.			ith	Pansy		May		Piercy		
S	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relation Teddy Smith/ I				ng Address <i>(Street</i> 44 Sonnet							
ore,			20a. Method of Disposition		20b. Pl		sition (Name of natory or other place	<u> </u>			tion - City or To			
<u>E</u>	. Pages Iment of tant: If its jury or o		1 ☐ Burial 2 ☐ Cremation 4 📆 Donation 5 🗍 Other (n 3 □ Removal from State (Specify)			fts Registr		3/2009	Hano	ver, Ma	ryland		
Ball	permit. Page Department Important: If any injury o		21. Signature of Funeral Service	ecensee			2. Name and Address 7522 Conn							
		2 3		st only one cause on each li	ine.	720		1	or respiratory arr	est,		Approximate Interval Between Onset and Death		
200	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. End	Sta	ge (2	rncor of	Cervix			•	unknuwn		
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6	execution and al-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequ	ence of):								
68760	ificate be executed physician and is the burial-transit	ca		d.		,								
_		ed	IF FEMALE:											
. Box	death certificate be executed e attending physician and id for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 🗌 Fetal	death 3	Ectopic pregnanc Other <i>(specify)</i>	у		230	d. Date of delive Month	ery Day Year		
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ords,	law requires that the death cert as been signed by the attendin 2 should be detached for use a	ģ	Part II. Other significant condi	lions contributing to death b	out not resul	Iting in the ur	nderlying cause give	en in Part I.				ne cause of death? pably 4 Junknown		
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	ding Physician: h. After this certific funeral director,	.To	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpation		ER/Outpatier		4 LI Nursing F	lome 5 Reside			y)		
0	th. : After e fune	tion	1 Natural 5 ☐ Pend	/A 4 AL 15-		Injury	Worl	yai (? Yes 2□No	28d. Describe ho	ow injury o	occurred			
Division of	I or Attendi after death. Director: A d in by the fu	ertification:	3 ☐ Suicide 6 ☐ Could	minod 286, Place of In	jury - At hor tc. (Specify	me, farm, stro	eet, factory, office		28f. Location (St City or Town		Number or Rura	il Route Number,		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: K completely filled in by the fi	Medical C	(Check only 2 Medica	ring Physician: To the best al Examiner: On the basis of and manner st	of examinati	ion and/or in	vestigation, in my o	pinion, death occu	urred at the time, d	ate and pl	lace, and due to	stated. the cause(s)		
	To th within To th	Me	29b. Signature and title of certifi	er			29c. Licens	e number	2	9d. Date s	signed (Month,			
			1 Lac	4clev8m	D		100	29d. Date signed (Month, Day, Year) 11. 2. 2009. 13. E-Ckton MD 21921.						
			30. Name and address of perso $S.S.S.Ac.H2$	n who completed cause of d	death (Item	23a) (Type, I	Print) Hich St	Elh	ton M.	02	1921.			
i	Sta Registr		31. Date filed (Month, Day, Year	9009 32. Registr	rar's Signati	ure for								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 35203 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NoVember Pay 2009 ar Marv Alice Fisher 10:50P /Medical 4a. Facility Name (If not institution, give street and number) Stella Maris 4b. City, Town, or Location of Death 4c. County of Death Examiner Timonium Baltimore | Honder 1 Year | Honder 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | May 30, 1922 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 213-16-9762 87 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, Ite Medical Expraires in the notified at Director 1 ☐ Yes XX No Maryland | Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2300 Dulaney Valley Road 21093 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2XXVo White þ Specify. XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Belchner Lillian Fisher Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any Injury or other trauonce. Mary Smith Daughter 1417 Valbrook Ct BelAir Maryland 21015 20a. Method of Disposition
1 ☐ Burial XXCremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State GreenMount Crematory 11/3/09 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) ignature of Funeral 5 22. Name and Address of FaMitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed המוס physician and page 2 should be detached for use as the hirrial.trev Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy perform **Division of Vital** 1 ☐ Yes Hospital or Attending Physician: 24 hours after death.
Funeral Director; After this certifica the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident (Month, Day, Year) 5 Pending investigation Injury 1 TYes 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) NURSE PRAYETT PLATES NER

State Registrar

MARY

10:50

DHMH 17 Rev 1/2001

29b. Signature and title of contifier

JACKÍE JONES,

31. Date filed (Month, Day, Year) NOV U 3

30. Name and add

2300 DULANEY VALLEY ROAD

ress of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

CRNP

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	U		For State Registrar		State	of Ma	ryland		artment of H rtificate of I				giene Reg. N	009	(35204
ī	Dhysiai		1. Decedent's Name	e (First, Middle, La	st)							2. Date of De Month	ath Day	Year	r	3. Time of Death
	Physicia /Medic		JAMES	SCOTT	FRAN	KLIN	1					0ct				15:05 p ^M
	Examin	er	4a. Facility Name (If	not institution, giv	re street and nu	umber)			4b. City, Town, or		4c. County of Death					
			5711 Ram			7 400	/In use le si	e de lande alexa el	Clinton If Under 1 Year	If Under	24 Hrs	8. Date of Bir		ince (
	Funeral Director		5. Social Security No.		Sex 12XIM 2⊡ F		(In yrs. lasi 7	Yrs.	Months Days	Hours	Min.	(Month, Da Nov 23	v. Year)	1	Jirthpia Country	ce (State or Foreign PA
			Usuel Residence of									NOV 22	, 190	1		A
	yland yland		10a. State	10b. County			10c. City, T	own or Lo	cation						100	I. Inside City Limits
	Mar B-f st	tor	MD	Prince	Georges		Clin	ton								1 ☐ Yes 2X No
	th the	Director	10e. Street and Nun	nber					10f. Zip Code				10g. Citizen of What Country?			/?
	23a	5711 Ramblewood Ave. 20735												USA		
	r dea	Funeral	11. Marital Status		12. Was Dec Armed F		ver in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba	gin? (Spe n, Puerto f	cify Yes or No Rican, etc.)). 1	 Race - An Black, Wh 			
2	or H	by Fu		ed 2 Married	If Yes, G		0		1 ☐ Yes 2 🛣 No	Specify:				Specify:	121	ack
5	hour turel'	q pe	3 Widowed	15. Decedent's E	Year or I	Dates:		ISa Dacay	dent's Usual Occup	ation			16h Kir	nd of Busines		
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4	iene.	mo	Elementary/Secon	ndary (0-12)	College (·)	Car	Sales				Po	hanka		
2	illed Hyg other	To Father's Name (First, Middle, Last) Charles J. Franklin, Jr. Call Sales 18. Mother's Name (First, Middle, Maiden Sumame) Agnes Talbert														
0	should be filed within 72 hours after death with the Maryland nd Mental bylgene. I marked other then "naturel" or Items 23a or 28a-f show umatic avent, I'm Medical Examination Item of the Jan															
aly	should have		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)												ode)	
2	1 and 2 should be filed within Health and Mental Hygiene. Iem 27 is marked other then other traumatic avent, I'm Ma		Brenda Franklin-Wife 5711 Ramblewood Ave. Clinton, Md. 20735													
ט כ			20a. Method of Disp		Bemoval from	State	20b. Plac	e of Dispo etery, crer	sition (Name of natory or other place	(8)	D	ate	20c. Lo	cation - City of	or Tow	n, State
	Pages ment of the ent: If ite ury or of	1 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Resurrection Cemetery 11-6-2009 Clinton, Md.														
Dal	permit. Pages Department of Importent: If i any injury or o	21. Signature of Euneral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, Md. 20746														
	TEUR!		23a. Part 1. Enter th	ne disease, or con rt failure. List only	plic flions that	caused t	the death. I	444				The second second			F	opproximate nterval Between
	Physician .		Immediate Cause (Final				art 1	Failure							Onset and Death
	/Medical		resulting in death)	-	W		consequen		rallule							
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5	cian a	E			D09 (0	(Orasa	consequen	ice oi):								
	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical			_ d										+	
S	ding I	0	IF FEMALE:		23c. If yes, ou	atcome o	of pregnancy	v						12d Date of d	lalisaas	
2	that the death certificated by the attending of detached for use as	Physician/M	23b. Was decedent in the past 12	months?	1 Live	birth 2	Fetal de	eath 3	Ectopic pregnancy Other (specify)	,			2	3d. Date of d Month	- 1	ay Year
;	y the	ıysic	1 □ Yes 2 □ 9 □ Unknown	□No	9□ Unkr		and or dead	3_								
	that ned by deta		Part II. Other signifi	icant conditions	contributing to	death but	t not resultir	ng in the u	nderlying cause give	en in Part I		23e. Did t	obacco u	se contribute	to the	cause of death?
2	uires that signed I	d by										1 🗆	Yes 2]No 3∏	Probab	oly 4 ⊠ Unknown
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0		ပိ	25. Was case refer	red to medical						26 Place	of Death	(Check only	2 🔯 No	1 🗆 Ye	es 2	∐ No
>		0 8	examiner? 1 ☐ Yes 2 🔀		Hospital:	Inpatien	nt 2 🗆 ER	VOutpatien	nt 3 DOA Oth	0.5		ne 5 ⊠ Resi		Other (St	oecify)	
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5	tendin death. tor: Aft the fur	27. Manner of Death 1 XNatural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury At home, farm, street, factory, office 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred														
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2	ital o	Cer				J	,,,,,									
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: Attercompletely filled in by the funer	edical	29a. Certifier (Check only one)	1 ☐ Certifying P 2 ☐ Medical Exe	miner: On the I	e best of basis of e nner state	examination	edge, death and/or in	n occurred at the tin vestigation, in my o	ne, date an pinion, dea	id place, a ith occurre	and due to the ed at the time,	cause(s) date and	and manner place, and d	as stat ue to tl	ed. ne cause(s)
	withir withir To th comp	Me	29b. Signature and	title of certifier	her	1	-		29c. Licens	e number			29d. Dat	e signed (Mo	nth, Da	ay, Year)
			1	1	-				D223	05			10/	29/200	09	
	5		30. Name and address		-				Print) Suite 4	07 Т	emp1	e Hill:	s, Mo	1. 2074	48	
	. Sta	te	31. Date filed (Mont				r's Signature									
	Registr	ar	NOV	0 3 2009	Beneur		1.	back	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Anna T. Fritz November 2009 8:27 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Center Towson Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** (Month, Day, 1 🗆 M 2 🔀 F Days Hours Min ountry) Maryland Director 217-12-5111 93 Ĭ916 A119 . Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Funeral Director MD Baltimore Timonium 1 🗌 Yes 2 🖾 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 12300 Rosslare Ridge Road Unit 205 21093 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by . Page 1 and 2 should be filed within 72 hours after iment of Health and Mental Hydiene. Furth If then 27 is marked other than "natural", or ury or other traumatic event, the Medical Examic ury or other traumatic event, the Medical Examic 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗷 No Specify: Specify: 3 Widowed 4 □ Divorced Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nicholas Till Barbara Blase 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicholas P. Fritz 12300 Rosslare Ridge Road Unit 205; Timonium, MD 2109 Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oth once. Holy Cross Cemetery 11/6/2009 1 🗵 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Baltimore,MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, MD 1630 Edmondson Avenue: Catonsville, MD 21228 21. Signature of Funeral Service Lip 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 8MAICATIONS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Fall Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence of APPROVED BY MEDICAL ELABORER dementin Al 2 homes Cause (Disease or iinjury that initiated events bunial-trar Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical certificate be Box 68760 as t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth
4 Pregnant :
9 Unknown in the past 12 months?

1 Yes 2 No
9 Unknown for Pregnant at time of death certificate has been signed by the rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The 24 hours after death. 1 ☐ Yes 2 ☐ No Yes 2 N **Division of Vital** Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗌 No ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury ☐ Natural Natural
Accident 5 Pending october 25 2009 2350 M 1 Tes Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office filled in by determined building, etc. (Specify) Nursing home Charles ST. TOWSON MD 7001 N. 24 hours a Medical 29a. Certifier 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 | 3 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, 1

6701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLIES

3 2009

MY

Registrar's Signature

November 2 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #30 per DVR g897 11/3/09 TT State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Gupta Sheela 2009 1025 Nov 02 /Medical 4b. City, Town, or Location of Death acility Name (If not institution, give street and number 4c. County of Death Examiner Olumbia er 1 Year | If Under 24 Hrs Howard Genera 8. Date of Birth Amonth, Day, Apr. 24 9. Birthplace (State or Foreign **Funeral** Min. 1 ☐ M 2 💢 F Months Days Hours Country) 125-62-6038 Director India Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expraising Trust be marified anone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No 10e. Street and Number 10q, Citizen of What Country? 3020 21042 758 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 2 3 Widowed 4 ☐ Divorced Indian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) tousew 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be (Vaina ပ gat 19a. Inf ant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21042ross Ell: with 3020 Lanc (90 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20c. Location - City of Town, State Date 09 4 ☐ Donation 5 Other (Specify) 21. Sign ture of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) acciden **Physician** cerebrovascular Sday /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any lating cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to lor as a consequence of or Attending Physician: The law requires that the death certificate be executed and the burial-tra Due to (or as a consequence of): P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐ Pregnant at time of death 9☐ Unknown 5 ☐ Other (specify) ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 4No 3 Probably 4 Unknown lama 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 14No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 (3 No Hospital: 1 ☐ Yes ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27, Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 66515 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10724 Little Patuxent Parkway Nish: Rawat MD Columbia, MD 21044 31. Date filed (Month, Day, Year)
NOV - 3 2009 32. Registrar's Signature State Registrar

Davren N 09-08279	lh	Green, Tr. Please Type	or Print in RI:	ack Ind	delible Ini	k Ensu	re All Coni	es Are I ec	iible		
UNK UNK		State		Depar	tment of	lealth ar	nd Mental		20	09 3520	
Dhorisi		<mark>1- For State Registrar</mark> 1. Decedent's Name (First, Middle,La	ot/	Cert	fificate of l	Death		Re 2. Date of Deat	g. No.	3. Time of Death	
Physicia Medical Exami		DARREN	NEAL	G	REEN	JR.		Month October 25	Day Year	0538 hrs	
e)		4a. Facility Name (if not institution, gi					or Location of Deat	n	4c. County of D	eath	
Funeral		Johns Hopkins Hospital 5. Social Security Number 6. S	iex 7. Age	(In vrs. las	st birthday)	If Under 1 Ye	ar If Under 24Hr	s. 8. Date of Birt	h(MM/DD/YYYY) 9	Birthplace (State or Foreign	
Director			M 2 F	24	Yrs.	Months Da		/	5 1985 N	MARY AND	
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Baltimore, MD 21215-0036 ermit. Pages I and 2 should be filed within 72 hours after death with the Maryland bepartment of Health and Mental Hygeine. mportant: If item 27 is marked other than "natural", or items 23a or 28a-f shi njury or other traumatic event, the Medical Examiner must be notified at once		1. Never Married 2 Marrie	d Armed Forces?	No No	If Yes		an, Mexican, Puert		White, et		
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Baltimore, permit. Pages I an Department of Hea Important: If iter	. 8	4 Donation 5 Other Specifical Signature of Funeral Service Lice		livie		me and Addre				JONES FIH, PF	
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Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the t		4 Homicide determin	(ap 60.0)/ EOC					1500 Block M	Iontpelier St., Bal		
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To To com	Med	29b. Signature and title of certifier	and manner stated				nse number			(Month, Day, Year)	
		Will	1	N	D	0.0	C.M.E.		October 26,	2009	
$\langle lacksquare$		30. Name and address of person who				Bonn Ctri	at Daltimass !	MD 21201			
	ote	Russell Alexander MD.	Assistant Medic			renn Stree	et, Baltimore,	VIU Z IZU I			
St Regis	tate trar	31. Date flaggy 10 37,2009	alema	A.	barles	7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month be Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 3886 1 □ M 2 💢 F Months Hours Min. (Month, Day Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified or 28a-f 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral , or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 No _ Yes Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NQT use retired) permit. Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Me /Seconday (0-12) College (1-4 or 5+) Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Pring Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 22. Name and Admess of Facility 21. Signature of Funeral Service Licenses BEIAT Funeral chopel Dr. Forest Hill mo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Dual to for an a correspondence within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? Month Dav 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury X Natural 5 Pending 1 Yes 2 No М Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and time of co 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

2009

OCTOBER

Registrar NOV 0.3 20

JACKIE JONES.
31. Date filed (Month, Day, Year)

10.4

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

ss of person who completed cause of death (Item 23a) (Type, Print)

32. Regetrar's Signature

CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GLADDEN Physician/ GLA DYS 0431M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Tate Hospice House Linthicum If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. (Month, Day, Year) ug. 7, 1924 Country)
Maryland Director 217-12-7530 85 Aug. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturo" any injury or other traumatic concer. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Anne Arundel Maryland <u>Severna Park</u> 10f. Zip Code 10g. Citizen of What Country? Funeral 21146 United States 600 McKinsey Park #504 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Earl Bell Rose Markey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21144 Patricia Hall / Daughter 336 Council Oak Dr. Severn, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Haven Mem. Park Nov. 4, 2009 Glen Burnie, Maryland Glen 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, 421 Crain Hwy. SE; Glen Burn 21. Signature of Figner 21061 Glen Burnie, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ma Ö disease or condition Medical resulting in death) Due to (or as a consequence of) ^{*}Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Yes signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s performed' 2 🗌 No Yes 2 No 1 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 No PICE 욘 funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of HOUSE 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural 5 Pending work 1 \square Yes 2 🗌 No after death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I

completed filled Medical 29a. Certifier 1🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

Registrar
DHMH 17 Rev 7/2009

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Name and address of person w

CYENSE

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TNNAPOUS MAZIKUI

o completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

amend #23a-d \$23PII Per PHY C917/09/09/15 In Health and Mental Hygiene

Amend Items 10a, f per fin, g899, 117/12/09/dnb For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ october 31, 200[°]9° 3:45 P M Walter Raymond Gibson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center @ GBMC Towson If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Social Security Number Days (Month, Day, Year, 1 🔀 M 2 🗆 F Hours Min. West Virginia Yrs. Director 1930 234-44-0147 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified W. VA 1 Yes 2X No Pennsylvania Braxton Frametown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 26601 26623 Box79 HC 61 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 \square No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72. hand Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Steel Manufacturing Steel Worker 10 Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ည Pearl Ida Bussey Raymond (nmn) Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other tra 825 Albion Place, Bel Air, Maryland, 21014 Carolyn Kaye Gibson/Daughter 20a. Method of Disposition

1 Burial 2 Di Cremation 3 4 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation Hilltop Service Corp. 11-3-09 Towson, Maryland Other (Specify al Savice Li at re of F 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Sig 1317 Cokesbury Road, Abingdon, Maryland 21009 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. **Sepsis** Approximate

Approximate

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Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Medical Radiation Injury months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi): months Treatment of Squamous Carcinoma Cause (Disease or linjury that initiated events executed and -trans Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Squamous Carcinoma of Head/neck months Physician/Medical Physician: The law requires that the death certificate be 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Division of Vital Records, P.O. Box in the past 12 months? Month Day Year Pregnant at time of death ed by the a detached f Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I signed by 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown has been signed by 2 should by 24b. Were autopsy findings available prior to completion of cause of autopsy certificate ha irector, page 2 perform death? 1 ☐ Yes 2 😿 ☐ Yes 2☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Other: 4 Nursing Home 5 Residence 6 To Other (Specify) 101911 Hospital: 1 ☐ Yes 2 🕅 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 3 Suicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my calcium death account at the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) cense number November 2 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nilharles at rowsin MD W 6701 Afren 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

Box 68760;

P.O. I

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	_	_ FOF	State of Maryland				lental Hygien	e 2000	25212		
		State Registrar		Certific	ate of L	Death	Reg. N	2009	35212		
Physicia	n	1. Decedent's Name (First, Middle, Last) Margaret H	tarnick				Month D	ay Year 25 2609	2,50 AM		
/Medica Examine		4a. Facility Name (If not institution, give str	c. County of Death	V 190 11							
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Funeral		5. Social Security Rumber 6. Sex	M 2 7. Age (In yrs. la	st birthday) If Un Yrs. Mont	der 1 Year hs Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthr	place (State or Foreign		
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tending Phy leath. tor: After thi the funeral of t	ii l	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? M 1 1 Yes 2				28d. Describe how injury occurred				
Atten r deat sctor: by the	tica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hon	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number,			
tal or safte al Dire	Certification: To	4 ☐ Homicide determined	building, etc. (Specify)				City or Town, Sta	ite)			
		(Check only 2 Medical Examina	cian: To the best of my knower: On the basis of examinati								
the lithin 2 the lomple	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number	29d. I	Date signed (Month	, Day, Year)		
FSFÖ		· Washing	and		2000	53337					
•	-	30. Name and address of person who con			1 /	~ 1			62009 Mdz1136		
		Dorothy Seay, 1		in Stre	2+ 3	Suite 2	00 Kewy	nwoter	11/12/136		
State	е	31. Date filed (Morhth, Day, Year)	32. Registrar's Signatu	ıre							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend # Steller Many 1890 be 14 1991 Health and Mental Hygiene

		_	For State Registrar		агулагы		tificate of E			Reg. No	2009	35213	
Phy	1. Decedent's Name (First, Middle, Last) Physician/ Robert Leo Harmon						2. Date of De Month Octobe						
	Medic camin		4a. Facility Name (if not institution,		4b. City, Town, or Location of Death				County of Death				
	(aiiiii	.	Summit Park Hea	1th & Rehab	Catonsville				Baltimore				
	neral ector				(In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hours					
P MO	<u>.</u>		Usual Residence of Decedent 10a. State 10b. County		10- 04-	T	-4:						
iryland •-f sho ied at		cto	10a. State									10d. Inside City Limits 1 Yes 2 No	
Desirinctey, Indexylating Z.I.Z.13-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: If tien Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	D I	Maryland Balting 10e. Street and Number	поге	Πά	aretno	10f. Zip Code				10g. Citizen of What Country?			
	Funeral Director	311 2nd Avenue				21227				USA	,		
death vitems		필	11. Marital Status	12. Was Decedent E Armed Forces?	401	13. V	Vas Decedent of His	spanic Origin	? (Specify Yes or No- uerto Rican, etc.)		14. Race - Ameri		
OUS after o	Completed by	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 X Yes 2 I If Yes, Give Year or Dates.		1953 1 □ Yes 2 🕅 No Specify:					Black, White, Specify: Whi			
2 hou	edica	plet	15. Decedent (Specify only highes		Ţ	(Give I	lent's Usual Occupa kind of work done d	ation uring most of	working	16b. k	Gind of Business In	ndustry	
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be filed wental Hyg	vent,		17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Si										
yidi Idbe i Menta	atic e	유	Frances Leo Harmon Rose Matild							a Plunnket			
shou and is m	ranm		19a. Informant's Name/Relationshi		ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
re, Maryiand t and 2 should be file f Health and Mental H tem 27 is marked of	thert		Alice Fay Harmo	on, Wife	20h Pla		2nd Avenue sition (Name of	e Hale	thorpe, Ma		and 2122 ocation - City or T		
Dalumit Page 1 ar Department of Ha Mportant: If iter any injury or oth	jury or o		1 ☐ Burial 2 💢 Cremation : 4 ☐ Donation 5 ☐ Other (Sp	ecify)	Met.	metery, cren ro Cre	ematory or other place	nc. 10	0/28/09	Ва	ltimore,	Maryland	
palle permit. Departri	any in		21. Signature of Funeral Service Lie	Thomas Gi	egor	22	Name and Addres remation 299 Frede	s of Facility Socie rick Re	ty Of Mary oad Baltin	/lan	d, Inc Maryla	nd 21228	
			21. Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one as see on each line. Approximate Interval Between Onnet and Death										
Physician/ Medical			Immediate Cause (Final disease or condition resulting in death) On et and Death Due to (or as a consequence of):									1 wx	
Exam			Casuantially list conditions	,		,							
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e death cer the attendi	thed for use										23d. Date of deliving Month	very Day Year	
s that th	g d	ρ	Part II. Other significant condition	s contributing to death b	ut not resul	ting in the u	nderlying cause giv	en in Part I.				the cause of death?	
aw requirer as been signal	should	letec		0-1	cho.	D V	neul	0)70	ul 24a. Was			ppsy findings available	
The law	ral director, page 2 s	Completed		- fart	Yen	عر			— auto	psy ormed?	prior to co death?	ompletion of cause of	
VILAI /sician; s certific	rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			Othe		Check only one)				
g Physicar this	eral dii	은 :a	27. Manner of Death	28a. Date of injur	y 2	28b. Time of	t 3 DOA 28c. Injury	4 Wursi	ng Home 5 Resh			y)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	e fune	icat	1 Natural 5 Pending 2 Accident Investiga		injury	work? M 1 Yes 2 No				Township Coods and the Cook of			
	d in by th	Certificate	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ne, farm, stre					(Street and Number or Rural Route Number, wn, State)				
Hospita 24 hours Funeral	eted fille	Medical	(Check 2 Medical Ex	Physician: To the best of aminer: On the basis of ex	kamination a	and/or invest	igation, in my opinio	n, death occur	rred at the time, date a	and place	e, and due to the ca	ause(s) and manner stated.	
To the within To the	compl	Σ	only one) 3 \square Certifying I 29b. Signature and title of certifier	Nurse Practioner: To the	ATA	- V	D 29c License	number		29d Da	te signed (Month	Day Year)	
				200		mo 1	03	694	2	0	tober?	1228	
15	+1		30. Name and address of person w	11/4, MD 10	29,		ley'ck	ed C	atory sil	le	, NO 2	1228	
Re	Stat gistra	E	31. Date filed (Month, Day, Year) NOV - 3	32. Registra	r's Signatu	re	a id.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35214 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Year GARET 07 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Mandarin Hospice House Anne Arundel Harwood der 1 Year | If Under 24 Hrs. If Unde 8. Date of Birth (Month, Day, Year) 08/14/1963 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1□M 2**Z**F Months Min. Days Director 004-68-6915 46 Maine Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shover the Medical Example at the Medical Example of the continued at 1 ∏Yes 2 ☐ No MD Calvert Director Huntingtown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3055 Queensberry Drive 20639 U.S.A. by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2X No Specify: 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Immigration and College (1-4or 5+) Elementary/Secondary (0-12) Legal Clerk Naturalization or other traumatic event. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev once. Bernard Shea Elizabeth Joyce ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marybeth S. Moore/Sister 3055 Queensberry Drive, Huntingtown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Ardent Cremation Services | 11/02/2009 | Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Servcices 21. Signature of Funeral Service Licenses Zaura . Hardess M01197 7522 Connelley Drive, Ste.N, hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -UNG MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause, Ulsease of injury that initiated events are this industrial to the cause of the caus Examine Due to (or as a consequence of) executed burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician law requires that the death certificate be Physician/Medical the IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) the 9 Unknown signed by 1 I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐Yes 2 ☐ No 24a. Was an has autopsy the Hospital or Attending Physician: The performed? certificate 1 ☐Yes 2 ☐No 25. Was case referred to medical Be 26. Place of Death (Check only one) MANDRIN Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28h Time of 28d. Describe how injury occurred itouse 5 Pending investigation 1 Natural death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year

29b. Signature and title of certifier

32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type Print

29d. Date signed (Month, Day, Year) Other 31, 2009

TUNAPOLIS MD 2140

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 30, 2009 Рм 8:25 Mae Belle Hamilton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ivy Hall Geriatric Center Middle River Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral Months (Month, Day, Year) 09/25/1919 1 🗆 M 2 🗶 F South Carolina Director 251-10-7255 90 Yrs. 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County e filed within 72 hours after death with the Maryland must be notified at **Funeral Director** 1 Yes 2 KNo Middle River Maryland Baltimore 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a U.S.A. 21220 12848 Cunninghill Cove Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. other traumatic event, the Medical Examiner Black, White, etc. o. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural" 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) arked other than Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mildred Iseman William Odom andis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12848 Cunninghill Cove Rd., Baltimore, Md. 21220 Linda Byus (Daughter) item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o Page 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/03/2009 Baltimore, Maryland 4 Donation 5 Other (Specify) Baltimore Cemetery 21. Si e of Fu Sanda 22. Name and Address of Sacilly Ski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Part 1.5 mer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): ng physician and as the burial-transit executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: res, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 [Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy performed? prior to completion of cause of death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 힏 1 ☐ Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 🔀 Natural 5 Pending work?
1 Yes 2 No Investigation Accident within 24 hours after deat To the Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

only one)

3 29b. Signature and title of certifier

Kwuma 31. Date filed (Month, Day, Year)

3

completed cause of death (Item 23a) (Type, Print) E50 1124 Mace

82. Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D006190

29d. Date signed (Month, Day, Year)

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 35216 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2009 Harvey Gary Allen 1:45p.M 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore 4103 Fairfax Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. Days Hours 1 🕅 M 2 🗆 F Country) Director 245**-**80-6011 50 20 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho Director Baltimore MD NA 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21216 4103 Fairfax Road Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 X Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Construction Construction Worker 11th grade na Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marita Harvey should be Leon Fowlkes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4103 Fairfax Road, Baltimore, Md 21216 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Marita Harvey-Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 11/21/09 Woodlawn, Donation 5 Other (Specify) King Memorial 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21. Sq a. of Funeral Service License Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused shock, or hear failure. List only one cause on each line. sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death
3 months Physician/ cancer ung disease or condition Medical resulting in death) Due to (or a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) detached for in the past 12 months? Month Year Day 2 🗌 No 1 ☐ Yes 2 L 9 ☐ Unknown the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate 1 Yes 2 No Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🛣 Residence 6 🗆 Other (Specify) ပ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death. М Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be To the Hospital or Atter within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c, License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

W Belvedere Ave Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2401 32. Registrar's Signature

Varlagacida

State of Maryland / Department of Health and Mental Hygiene 2009 35217 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 11/2/2009 4:30 P M Stephen Alan Haugh /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospital Center Westminster If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Hours Months Days 12EXM 2□ F 9/7/1955 54 216-48-4808 **Director** MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Funeral Director 1 Yes 2K No Carroll MD Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21157 USA 751 Gist Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Completed by If Yes, Give Year or Dates: Specify: White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Carroll Hospice other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Is marked of Pages 1 and 2 should be Margaret Hutchins ပ Ernest N. Haugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Dave Haugh/ Brother 16970 Frederick Rd., Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Pine Grove Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/6/2009 Mt. Airy, MD 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory, P.A
1212 W. Old Liberty Rd., Winfield, MD 21784 21. Signature of Fariera 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as - consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funheral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal-transit Due to (or as consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed, (Month, Day, Year) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ajay Behari, 200 Memorial Ave., Westminster, MD 21157 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

21215-0036

Baltimore. Maryland

Box 68760,

of Vital Records, P.O.

Division

State Registrar

Physician /Medical Examiner

Funeral Director

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9b. Signature and title of certifier Pyrmy mb 1906 November 1,2009 D. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tenny Tuan 22 South Greene St. Baltimore, MD 21201	(Check only 2 Medical Exam	iner: On the basis	of examination	ige, death o and/or inve	occurred at the	e time, date a ny opinion, de	and place, eath occurr	and due to the red at the time,	cause(s)	and manne place, and	r as stated due to the	cause(s)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 1:46 B M TJUAC HEN DERSHOT MOUEHBER 1, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDER GUEN BURNIE BACTIHORE - WASHIHETOH HEDICAL CENTER f Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 22,1940 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Days Hours Yrs Pennsylvania **Director** 182-32-6771 Usual Residence of Decedent 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Anne Arundel Co. Odenton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 23a 1149 A Odenton Road 21113 United States Funeral or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status and 2 should be filed within 72 hours after of tealth and Mental Hygiene. m 27 is marked other than "natural", or iten 1 Never Married XX Married 1 ☐ Yes XX No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Brewer Beatrice Gray ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4. Pages 1 and and and of the alth and 27 is Mr. Maynard L. Hendershot/Husband 1149A Odenton Road Odenton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important; If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 11/05/2009 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK disease or condition resulting in death) 1241 /Medical Due to (or as a consequence of) Aidodusala 20M10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SLAJZIO VARHONJUS JUITOURTZBO 1 Xes 2 No 3 Probably 4 Unknown 24a, Was an 1 □ Yes

Physician Examiner

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed Box 68760, Ö σ. Records, Division of Vital

2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No

25. Was case referred to medical examiner? Hospital: 1∐Yes 2⊠No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nation 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

and manner stated

29c. License number

D0065+14

26. Place of Death (Check only one)

29d. Date signed (Month, Day, Year) HONEHBEK 175008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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OJJAJUAID JOOC OMAJJJIUD 301 HOSPITAL DRIVE, ELEH BURNIE, MD 20161 31. Date filed (Month, Day, Year)

State Registrar

Be

Certification: To

Medical

29b. Signature and title of certifier

Director: d in by the f

within 24 hours a

To the Funeral I

completely filled

DHMH 17 Rev 1/2001

For State Registrar	
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1. Decedent's Name (First, Middle, Last)

Certificate of Death

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2. Date of Death

35220

Physician

Physician /Medical Examiner

21215-0036

Baltimore, Maryland

P.O. Box 68760, Records, Division of Vital

Perry T. Hough october 31, 2009 12:25 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4770 Owings Mills Blvd. Owings Mills Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 02/25/1938 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Funeral Days Hours 1**XX**M 2□ F Connecticut 043-30-3873 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Machal Examinar must be maritted. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits CTDirector Newington 1 X Yes 2 □ No Hartford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 114 Reservoir Road 06111 United States Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo White Specify: 3 ☐ Widowed 4 Z Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Psychologist Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Perry Tyler Hough Althea Goodale ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew E. Hough / Son 904 Huddersfield Ct. Owings Mills, Maryland 21117 20a. Method of Disposition
1 ☐ Burial 2 ☐ Femoval from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Atlantic Crematory 11/02/2009 Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility David J. Weber Funeral Homes PA 21. Signature of Funeral Service 401 S. Chester Street Baltimore, Maryland 21231 Vanco 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, st only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attendeath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. of person who completed cause of death (Item 23a) (Type, Print) 6+1 I' WU ernert erson

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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Fu Dir permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 Phys /Me Exan

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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nysicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month October	Day 31 2009	3. Time of Death 17:345 M	
Medic xamin		John A. Harrison 4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death	october	4c. County of Death		
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hould b							2 No 3 F	2.	
2 5	Completed					24a. Was an autopsy performe 1 ∐ Yes 2 5	d? prior to	autopsy findings available completion of cause of	
ector, p	Be C	25. Was case referred to medical examiner?		low	26. Place of Death		givo Time	2.2110	
eral din	n: To	1 ☐ Yes 2 ဩ No Hospital: 1 ☐ Inpatii 27. Manner of Death 28a. Date of Inju	ury 28b. Time o	f 28c. Injui	ry at	me 5 Residence 28d. Describe how	ce 6 ☐ Other (Sp injury occurred	pecify)	
the fun	catio	1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			lYes 2□No				
d in by	Certification:	determined 20e. Flace of iti	ury - At home, farm, str c. <i>(Specify)</i>	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,	
completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 CertifyIng Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination and/or in	h occurred at the ti	ime, date and place, opinion, death occur	and due to the cau red at the time, dat	use(s) and manner e and place, and du	as stated. ue to the cause(s)	
сотр	Me	29b. Signature and title of certifier		29c. Licens	se number	290	I. Date signed (Mor	nth, Day, Year)	
XI		Ill Kosest	da - Ab / / A	D098	34		11/2/20	09	
1		30. Name and address of person who completed cause of c Barry Rosenbaum, M.D., 3720) Farragut	Avenue, I	Kensingtor	n, Maryla	nd 20895		
Sta legistr		31. Date filed (Month, Day, Year) 32. Registr	rar's Signature						
		MANAY RAPE CHINA	100						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 35222 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month / O Physician/ UESTIS 4 24 M DOD I Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗷 July 30, 1939 Months Days Hours Country) 212-36-5161 WV **Director** 70 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10a, State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2004 Norman Road 21060 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. ģ 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates ☐ Yes 2X No Specify Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nit. Page 1 and 2 should be filed within 72 artment of Health and Mental Hygiene. ortant: If item 27 is marked other than injury or other traumatic event, the Me Elementary/Seconday (0-12) 12 College (1-4 or 5+) Supervisor Convenience Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ray Bowers Clarice Baker 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2004 Norman Road Glen Burnie, MD 21060 Mr Barry M. Huestis Sr./ Baltimore. 20a. Method of Disposition
1 → Burial 2 → Cremation 3 → Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. Date 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 2009 Glen Burnie, Maryland 21. Signature of Funeral S 22. Name and Address of Facility Singleton Funeral & Cremation any any Services PA 1 2nd Ave SWGlen Burnie, MD 21061 MOHZI replications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List of yone cause on each line Approximate Interval Betwe Immediate Cause (Final oncl Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death
☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year sate has been signed by the spage 2 should be detached in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Tes 2 No 2 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No Yes 2 within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes No. 📶 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check з 🗌 Certifying Nurse Practioner: To best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif use of death (Item 23a) (Type, Print) DEFENS my41

State Registrar 31. Date filed (Month, Day, Year

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 38 3009 Day **Physician** 10 PM te ves vely /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ohrs Hopkins Bayores CareCort Baltimore 2000 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕶 F Months Days Hours Min Director 72 212-34-7977 Oct. 13,1937 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show items 23a or 28a-f shree must be notified Director Maryland Baltimore Edgemere 1 ☐ Yes 2 X No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2400 Lincoln Ave. Lot 9 permit. Pages 1 and 2 should be filed within 72 hours after death w. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any lnjury or other traumatic event. 21219 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ XNo Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Manufacturing Western Electric Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٥ Andrew A. Hevesy, Sr. Mary A. Schneider 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9687 Middleford Road Seaford, DE 19973 Andrew A. Hevesy, Jr. (Brother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ■Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 11/2/2009 Middle River, MD 21. Signature of Funeral Service Light see 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 14 **Physician** disease or condition resulting in death) cc hu /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed aftending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the at d be detached fo 5 Other (specify) □Yes 2□No P.0. 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? cate has I page 2 s certificate 2. No 2 🗆 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by after 4 Homicide 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D04383 October 28 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 Hoph Bay view Cirele MO W. 13 wee hought Baltimare 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

35224 State of Maryland / Department of Health and Mental Hygiene 2009

			StateRegistrar					Ce	rtifica	te of [Death			Reg. N	lo.			
			1. Decedent's Name	e (First, Middle,	Last)								2. Date of D				3. Time of De	ath
	Physicia Medic		R	Robert H	ludson I	nhof	f, Jr	•					Month Novemb	er	3, 20	009	4:03 A.	М
0	Examin		4a. Facility Name <i>(if</i> Gilchri		give street and nu pice Cent					y, Town, or OWSOI		of Death			c. County of Balt:			
	Funeral Director		5. Social Security Nu 215-22-34		5. Sex 1ÄOKM 2 ☐ F	7. Age	(In yrs. las	82 Yrs.	If Und Months	er 1 Year Days	If Under Hours	r 24 Hrs. Min.	8. Date of Bi (Month, D 2/10/	rth ay, Year)	7	Coun	olace (State or Fo try) Maryla	_
	3		Usual Residence of										2/10/	172	, ,		• FIRAL Y IC	ALICA
	sho	tor	10a. State	10b. County			10c. City,	Town or Lo	ocation							1	0d. Inside City L	imits
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	death i tem ner n		11. Marital Status		12. Was Dec		ver in U.S.	13.	Was Dece	edent of Hi	spanic Or	rigin? (Spe	cify Yes or No Rican, etc.)	na.	14. Race	- Americ		
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8	ours a	etec	3 Widowed	4 ☐ Divorced 15. Decedent	Year or I	ates.												
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/lar	d be f denta irked	욘	Robe	ert Huds	on Inhoi	f,	Sr.				V	ola (Olivia	Tanı	ner			
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Baftimore,	Page 1 and ment of Her ant; If item ury or othe		20a. Method of Disp 3대 Burial 2		B Removal from	n State	20b. Pla	ace of Disponentery, cre UIA	osition (Na matory or	ame of other plac	e)	Noven	Date Noer 6,	20¢.	Location - 0	City or To	wn, State	
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Bai	permit. Page Department of Important: If any injury or once.		21. Signature	100	Del				232	5 Yor	k Ro	ad T	limoniu	un. I	&Cre	mati and	on Ctr., 21093	,P.A
· v			23a. Part 1. Enter the shock, or hear	he disease, or c t failure. List on	omplications that ly one cause on e	caused ach line	the death.	Do not ent	er the mo	de of dying	g, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Betwee	
	Physician		Immediate Cause (F disease or condition	Final	_ a _ S	EP	515									- 27	Onset and Dear	th
2	Medical Examiner		resulting in death)	4	Due to	(or as a	conseque										,	
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T o u	Attending Physician: The law is death. ector: After this certificate has I extra funeral director, page 2 sy the funeral director, page 2	Certificate:	1 Natural 2 Accident	5 Pending Investiga	(Mo	nth, Day,	Year)	injury	' м	28c. Injury work	rat ? Yes 2 □	_	28d. Describe	how inju	iry occurred	d		
	Atter er dea ector by the	ا ليّ	3 Suicide 4 Homicide	6 Could no	ot be 28e. Plac		ry - At hom	ne, farm, str	eet, facto	ry, office		2				or Rural	Route Number,	
	Hospital or 24 hours afte Funeral Dir sted filled in				bullo	ling, etc.	(Specify)						City or To	wn, Stat	re)			10
M M	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check 2	Medical Exa	hysician: To the aminer: On the ba lursa Fractioner	isis of ex	amination a	and/or inves	tigation, ir	my opinio	n, death o	ccurred at	the time, date	and plac	e, and due	to the cau	ise(s) and manner	r stated.
H	To t with com		29b. Signature and t			57		7	- 1	c. License		95			ate signed			9
	nx1,		30. Name and addre	ess of person wh	no completed cau	se of de	ath (Item 2	23a) (Type, I	Print)	04		, -	I	1=01	LINC	LK	0100	
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	Stat Registra			IOV A O	1	Hyistrai	r's Signatur	e e		a								

For

State of Maryland / Department of Health and Mental Hygiene For State Registrar 35225 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** 2009 11:30a^M 10 30 Johnson Margaret /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death Examiner Balto 967 Sandalwood Road Essex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min. 1 □ M 2X F 90 2-19-1919 Director 219-01-3777 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It o Madical Examinar by rediffied at once. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 □Yes 2 □No MD Directo Balto Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 967 Sandalwood Road 21221 U S Δ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Black Specify: Completed by 3€Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) C & P Telephone Telephone Operator 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Annie Williams James Dunlap ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tanya hamilton Granddaughter 967 Sandalwood Essex, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Pk 11-7-2009 Randallstown, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H BMMM MD 21202 1101 E. North Avenue Balto, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Hospital or Attending PhysIclan: The law requires that the death certificate be executed Exam attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 | Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) is certificate has been signed by the director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Demention 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) SARAH CLEVER 11/2/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 147143 Bu 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

			For State		State of Ma	arylan					and M	1ental Hy	/gien	e 20	0.0	25226
	_		Registrar 1. Decedent's Nam	e (First Middle I a	ret)		Cer	tificate	of D	eath				No. 20	09	35226
	Physici			LES A. J.	,							2. Date of De Month			Year	3. Time of Death
	Medi Exami				e street and number)			4b. City, To	own or l	Location		NOVEMB	BER 1, 2009 4c. County of Death		13:15 A.™	
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	Funeral		5. Social Security N	umber 6. S	Sex 7. Age		ast birthday)	If Under 1	Year	If Under	24 Hrs.	8. Date of Bi	rth			ace (State or Foreign
	Director		212-32-2	701	X M 2 □ F	74	Yrs.	Months	Days	Hours	Min.	4/14/19	335 °) .	MARY	LAND
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	or 28g	E E	10e. Street and Nur					10f. Zip (Podo.				10	201		
	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If It them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Director	215 BELM		ST COURT L	NIT	101	,	2109	93			10g. C	Ditizen of Wh		ry ?
ë	deatl r iter ner n		11. Marital Status		12. Was Decedent En Armed Forces?			as Deceder Yes, specif	nt of His v Cuban	panic Ori . Mexicar	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race -		
a.m	after al", or xami	d by	1 ☐ Never Marr 3 🛣 Widowed	ied 2 Married	1 Yes 2 X	lo lo		Yes 2				,		Specify:	White, e	
200	atura cal E	Completed	o Es Widowed	15. Decedent's E	Year or Dates.	- 71	16a. Decede	ent'e Heust	Occupat	tion			1 400		WHI	
3:15	n 72 h an "n Medi	E I	(Spe	cify only highest gr	ade completed)	, —	(Give k	ind of work NOT use n	done du	iring mos	t of workir	ng	166.	Kind of Busi	ness Ind	ustry
2	d withi	Be Co			2 YEARS	,	SELF	EMPL	OYEL					WN BU	SINE	SS
NOVEMBER 1, 2009 Baltimore, Maryland	and 2 should be filed within 72 hours afti Health and Mental Hygiene. em 27 is marked other than "natural"; ther traumatic event, the Medical Exar	To B	17. Father's Name (I JOSEPH	First, Middle, Last) T. JAMES	5							(First, Middle, HAMPT	Maider	n Surname)		
ary	nould ind M s mar umat		19a. Informant's Na	me/Relationship (7	Type, Print)		19b. Mailing	Address (Street an	-		Route Numbe	er City o	or Town Stat	te Zin Ci	odel
R Z	and 2 sl Health a em 27 i ther tra		STEVEN P	JAMES/S	SON		6806	RIDG	EWOC	D RD		_		2128	_	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
NOVEMBER Saltimore,	t of Hea t of Hea If item or othe		20a. Method of Disp		Removal from State		ace of Dispos emetery, crem)	D	ate	20c. l	Location - C	ity or Tov	vn, State
VE T	permit. Page Department Important: I any injury o		4 Donation	5 Other (Speci	fy)	MET	RO CRE					4/2009		TONSV		
No Bal	permit. Page Department Important: I any injury o		21. Signature of Fur	neral Service Licen: Hay	IMO	1139	22. 8	Name and . 521 LO	Address OCH	of Facilit	y THE N BL'			UNERAL N, MD		ME, P.A. 286
			23 / Part 1. Enter to shock, or hear	ne disease, or cont t failure. List only o	plications that caused one cause on each line.	the death										Approximate
7	Physician/	Ш	Immediate Cause (I disease or condition	inal	a. CHRONIC	ORST	RIICTIV	r piir	MONIA	יו עמ	TCFA	CF.				Interval Between Onset and Death
	Medical Examiner	П	resulting in death)		Due to (or as a	conseque	ence of):				TOLK	JL.				-
		je.	Sequentially list con	nditions, mediate	b. — Due to (or as a	conseque	ence of:	_							_	
.0.	ted J unsit	Examiner	cause, Enter Under Cause (Disease or i	iying injury											- I	
ho	e be executed ysician and e burial-transit	ŭ	that initiated events resulting in death) L	ast	C. Due to (or as a	conseque	ence of):									
00	ate be ohysicia the bur	edical			l d				-							
876	tificat ng ph as th	Me	IF FEMALE:													
Box 68760	ath certific attending p	ian/	23b. Was decedent		23c. If yes, outcome of 1 Live Birth 2	Fetal	death 3	Ectopic pre	gnancy				-	23d. Date of	of deliver	y
Bo	e dear the at hed fo	Physician/M	1 Yes 2 Unknown		4 ☐ Pregnant at t 9 ☐ Unknown	ime of de	eath 5	Other (spec	ify)					Month		Day Year
S.0.	requires that the des been signed by the s should be detached			cant conditions co	ontributing to death but	not resu	Iting in the un-	derlying cau	use giver	n in Part I		23e. Did to	hacco	use contribu	ite to the	cause of death?
JAMES rds, P.	ires ti sign	d by										10				bly 4 Unknown
ord	v requ	lete										24a, Was				y findings available
CHARLES JAMES Vital Records, P.O.	The law cate has page 2	Completed										autor	sy rmed?	prio dea	r to com th?	pletion of cause of
AR	ian: 1 artifica ctor, p		25. Was case referre examiner?	d to medical					26. Plac	e of Deat	h (Check		2 A J N	10 1	Yes 2	L NO
5 ≥	hysic his ce I dire	은	1 ☐ Yes 2 🗶	No	Hospital: 1 ☐ Inpatier	t 2 🗆 E	R/Outpatient	з □ роа	Other:	4 🗆 Nu	rsing Hon	ne 5 🗆 Resid	lence (6 X Other (S	Specify)	HOSPICE
) of	ling P n. After ti funera	Certificate:	 Manner of Death Natural 	5 Pending	28a. Date of injury (Month, Day,	Year) 2	28b. Time of injury	28c	. Injury a work?	ıt	2	3d. Describe h				
ior	ttend death stor: /	tific	2 Accident 3 Suicide	Investigation 6 Could not be				М		es 2 🗆						
Division	tal or A s after al Direct		4 L Homicide	determined	28e. Place of Injury building, etc.	Specify)	ne, tarm, stree	t, factory, o	пісе		2	8f. Location (S City or Tow	treet ar n, State	nd Number o e)	r Rural R	oute Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. On the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2	Medical Exami	sician: To the best of m ner: On the basis of exa se Practioner: To the be	mination a	and/or investio	ation, in my	opinion.	death occ	curred at t	he time date a	nd place	and due to	the cause	e(s) and manner stated.
	To t To t			tle of certifier	PAIP				icense n		37.			ate signed (IV		
	አ	-	30. Name and address	s of person who c	ompleted cause of dea	th (Item 2	3a) (Type, Pri	nt))/7	/ /			/	14		
	7		JACKIE J	ONES, CR					D.	TIMO	NIUM.	, MD 21	093			
	Stat	_	31. Date filed (Month	Day, Year)		Signatu		-01	9							
	Registra	"		NUY U 3 Z	Jener	w,	13. All	MARIN								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2009 16:39 p ^M November Mary Esther Kramer 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Jan. 13, 5. Social Security Number 7. Age (In yrs. last birthday) Days Months 1 □ M 2 🖾 F Yrs. 75 Colorado 552-44-6240 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 1 ☐ Yes 217 No Anne Arundel Crownsville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21032 76 Summerhill Mobile Home Park 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc 1 ∐Yes 2 ŽNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Viola unknown James D. Stoger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 76 Summerhill Mobile Home Park, Crownsville, Maryland 21032 Terri L. Wyatt/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 2. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston Au BSO 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final wel/ disease or condition resulting in death) Due to (or as consequence of): heart failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Dav Year in the past 12 months? 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Obesity - / yno ventillation Syndrome 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ependent Diabetes Type 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 No
27. Manner of eath

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

2

Completed

Be

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item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

l Hygiene. should be filed within

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othany injury or other traumatic event

Saltimore,

72 hours after death with the Maryland

/Medical

10a State

requires that the death certificate be execute

Examiner

Physician/Medical

Completed by

Be

Medical Certification: To

1 Natural

2 Accident

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier (Check only one)

the burial-tran physician attending ph for use as the the detached signed by t be detach certificate has page 2 Physician: director, this

P.O.

Records,

Division of Vital

After th funeral Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State

Registrar

5 Pending

investigation

6 Could not be determined

29b. Signature and title of certific

Hospital:

29c. License number D002917/ 11-01-2009

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 \(\text{Nursing Home} \) 1 \(\text{Residence} \) 6 \(\text{Other} \) (Specify)

28d. Describe how injury occurred

Name and address of person who completed cause of death (Item 23a) (Type, Print

2225EDefense Hux Crofton MD 21114 31. Date filed (Month, Day,

28a. Date of Injury (Month, Day, Year)

and manner stated.

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28h. Time of

09-08392	
Robert Keith	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	•	Certificate of Death	Reg. No. 200	
Physician/ ledical Examiner	1. Decedent's Name (First, Middle, Last) Robert Lee Keith		2. Date of Death Month Day Year October 29, 2009	3. Time of Death 1315 hrs
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Baltimore	4c. County of Death	
Funeral	610 Arsan Avenue 5. Social Security Number 6. Sex 7. Age (In)	yrs. last birthday)		place (State or
Director	216-68-6317 1X M 2 F 4	Months Days Hours Min.	1/5/1963 Foreign Cour	ntryMaryland
any	Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Location		10d. Inside City Limits
		Baltimore		1 X Yes 2 No
	10e. Street and Number 610 Arsan Avenue	10f. Zip Code 21225	10g. Citizen of What Count U.S.A.	ryr
or items 23a : must be noti	11. Marital Status 1 X Never Married 2 Married Armed Forces?	in U.S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		an Indian, Black,
한 등리 교	3 Widowed 4 Divorced If Yes, Give Yeer		Specify: Whi	te
hours aft natural" Examine	15. Decedent's Education (Specify only highest grade complete	ed) 16a. Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use reti		dustry
215-0036 be filed within 72 hours after ntal Hygiene. rked other than "natural", ent, the Medical Examiner Be Completed by I	Elementary/Secondary (0-12) College (1-4 or 5+)	Truck Driver	Transporti	ng
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica fo Be Complé	17. Father's Name (First, Middle, Last) William	Keith Elsie	(First, Middle, Maiden Surname)	Wendling
	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or F		Zip Code)
m 2 aur	Bradley Ginis/ Son 20a. Method of Disposition	3526 Horton Avenue, 20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or	
Baltimore, permit. Pages I ar Department of He Important: If ite injury or other tr	1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other Specify:	crematory or other place) Anatomy Gifts Registry 11,	/3/2009 Hanover, M	Maryland
Baltimo permit. Page Department o Important: injury or oth	21. Signature of Funeral Servic Licensee		atomy Gifts Registr ., Ste. P, Hanover,	
Physician	23a. Part I. Enter the disease of complications that caused the c			Approximate Interval Between Onset and
Medical xaminer	•	and alcohol intoxication		Death
	Sequentially list conditions, b.			
ed nsit Examine	if any, leading to immediate Cause: Enter Underlying Cause (Disease or injury that initiated			
nted nd ransit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequent d	nce of):		
760, icate be executed by physician and the burial - transit		7,28a-f,permE, g898 12/4/0	09 TT	
5876 ertificate ding phy e as the l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of	2 Fetal death 3 Ectopic pregna	23d. Date of delivery ancy Month D	oay Year
b. Box 687. The death certification of the attending pother attending pother for use as the Physician/R	1 Yes 2 No 9 Unknown g Unknown	of death 5 Other (Specify)		
i, P.O. B rest that the d signed by the detached d by Phy	Part II. Other significant conditions contributing to death but	not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to 1 Yes 2 ✓ No 3 Prob	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced in by the funeral director.			24a. Was an 24b. Were au	topsy findings available
tal Recolinar: The law certificate has ector, page 2 st			performed? death?	
Vital Recysician: The I his certificate I director, page	25. Was case referred to medical examiner? Hospital: 1 Inpatient	26.Place of Death (Check 2 ER/Outpatient 3 DOA Other Nursin	only one) ng Home 5 Residence 6 ✔ Other	: Scene
n of Vi ding Physi a. After this funeral dir	27. Manner of Death 28a. Date of Injury (Month. Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
ision Attendi rector: by the f	Natural 5 Pending Provided Investigation Provided Provide	O9 Fd 1:05 pm 1 Yes 2 No -At home, farm, street, factory, office building, etc.	unk 28f. Location (Street and Number or Ru	ral Route Number, City
Division ospital or Attending nours after death. Increal Director: After filled in by the fune Certification:	3 Suicide 6 X Could not be 4 Homicide 6 X Could not be determined (Specify) House		or Town, State) 610 Arsan Ave Balt	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Functal Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical E.	one) 2 Medical Examiner: On the basis of examina	owledge, death occurred at the time, date and place, and aton and/or investigation, in my opinion, death occurred	d due to the cause(s) and manner as state at the time, date and place, and due to the	ed. e cause(s)
To with Tour com	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo.	nth, Day, Year)
	Mayore Meyhad	O.C.M.E.	October 31, 2009	9
	Name and address of person who completed cause of death Margarita Korell MD. Assistant Medical Exa	aminer 111 Penn Street, Baltimore, MD	21201	
State	31. Date filed (Month, Day Year) 2009 32. egistrar's S	Signatur barre		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 35229 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 04:30 PM 2000 Thomas Earl Kaiser OCT /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** AGNES BAL HOSPITA OMI If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours tx□ M 2□ F 217-26-7536 Yrs Director 88 1921 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Westers Examiner must be matified at 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Ln. BR 521 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Govt. Chemist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ambrose Ε. ဂ္ Kaiser Mildred Brotherton Μ. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Stafford (Per. Rep.) 1734 Maple Ave., Hanover, MD 21076 20b. Place of Disposition (Name of Baltimore Crematory) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/27/09 @ Loudon Park Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service License 3620 Wilkens Ave., Baltimore, MD 21229 23 Annu. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** 25 DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Unsees or mijury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be execute Due to (or as a consequence of): KAISER T. EARL Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) g Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2.0 No 1 ☐ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural To the Hospital or Attendl within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State

900 ONQUILLO 31. Date filed (Month, Day, Year) 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Registrar

29c. License number

S CATUN AVENUE

29d. Date signed (Month, Day, Year)

BALTIMORE MO 21279

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10/28/2009 **Physician** 1052A Kareri /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Days) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 7/15/1957 Kenya 52 Director 577987946 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director Silver Spring MDMontgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20906 1526 Ingram Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Specify: Black þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banker Government 5± 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wargumo Esther Paul Nbuthia 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) Silver Spring, MD 20906 Nene Kareri/Wife 1526 Ingram Terrace Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3√√ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/21/09 Muranga, Kenya Kiriaini Cemetery 21. Signatur of Funeral Service Licens 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy St. N.W. Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial Infarction resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, it is a sequentially list conditions, it is a sequential sequential sequential initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-tran <u>Hyperlipidemia</u> and Due to (or as a consequence of): P.O. Box 68760, the attending physician by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy detached for Month 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🔏 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 ☐ Yes 2 🕅 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 X ER/Outpatient 3 □ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation **XX**Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, completely filled in by the funeral director. 24 hours after deather seather: Hospital To the I within 2 To the I

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. Patrick Murphy, MD

and manner stated.

10/28/2009

29d. Date signed (Month, Day, Year)

1500 Forest Glen Road

1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D41624

29c. License number

Silver Spring, MD 20910

31. Date filed (Month, Day, Year) 32. Registrar's Signature

09-08354	
Gregory Kupchak	

regory Kupchak	State of Maryland / Departme 1- For State	ent of Health and Mental H ate of Death	lygiene Reg. No	2009 3523
Physician/	Registrar		2. Date of Death	3. Time of Death
edical Examine	GREGORY KUPCHAK		Month Day October 28, 20	1028 hrs 1c. County of Death
	Facility Name (if not institution, give street and number) 1686 Justin Drive	4b. City, Town, or Location of Deat Gambrills		Anne Arundel
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Min		WDD/YYYY) 9. Birthplace (State or Foreign Country) NY
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
*	MD ANNE ARUNDEL GAME	BRILLS		1 Yes 2 X No
the Maryland a or 28a-f show tifted at once. Director	10e. Street and Number	10f. Zip Code 21054	10g. C	itizen of What Country?
3a or 3			USA Planting Planting	
and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiers. Transmite event, the Medical Examiner must be notified at once traumatic event, the Medical Examiner must be notified at once To Re Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (\$\) If Yes, specify Cuban, Mexican, Puerl		14. Race - American Indian, Black, White, etc.
fler de l', or i	3 Midowed 4 Divorced III Yes, Give Year	1 Yes 2 XNo specify:		Specify: WHITE
ours aft	15. Decedent's Education (Specify only highest grade completed) 16a.	Decedent's Usual Occupation (Give kind or during most of working life, DO NOT use re		COMMEDICAL DEAL
36 in 72 hour han "natu lical Exan	Elementary/Secondary (0-12) College (1-4 or 5+) 2 YEARS F	PROPERTY MANAGER		COMMERCIAL REAL ESTATE
215-0036 be filed within 7 and Hygieneked other than ent, the Medica	17. Father's Name (First, Middle, Last)	18.Mother's Nan	ne (First, Middle, Maide	en Surname)
215 be file rrked o	HARRY KUPCHAK		A PARFOMCH	
b 21 should and Med 7 is man	19a. Informant's Name/Relationship (Type, Print) SONYA KUPCHAK/MOTHER	b. Mailing Address (Street and Number o 398 HOFFMAN LANE H		
e, MD and 2 sho Health and item 27 is traumati	20a. Method of Disposition 20b. Place of	of Disposition (Name of cemetery,	Date 20	c. Location - City or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 permiter. I file the lath and Mental Hyghers Important: If liter 3's marked other than injury or other traumatic event, the Medical To Be Comple	1 X Burial 2 Cremation 3 Removal from State WASHI	tory or other place) NGTON MEM. PARK 11	/2/2009 M	MT. SINAI, NY
caltin	21. Signature of Funeral Service Licensee MOO2 17			FUNERAL HOME, P.A.
	23a Part I. Enter the disease, or complications that caused the death. Do no	8521 LOCH RAVEN ot enter the mode of dying, such as cardiac		/SON, MD 21286 shock, or heart Approximate Interval
Physician /Medical	failure. List only one cause on each line	omplicating obesity		Detween Onset and
raminer	Immediate Cause (Final disease or condition resulting in death) a. HINI INITUENZA CC	Smplittering obobies	001010	P. Maria
i.	Sequentially list conditions, If any leading to immediate Due to for as a consequence of:			
isi ed	cause. Enter Underlying Cause (Disease or injury that initiated control receiving in death). Last Due to (or as a consequence of):			
executed lal - transit	events resulting in death) Last Due to (or as a consequence of).			
6 a a l	X UNPENDED AMENDED 23a, 27,]	per EM g897 11/10/0	9 TT	
3760 ficate l g phys s the bu				23d. Date of delivery Month Day Year
Box 6876(he death certificate the attending phy:	past 12 months? 4 Pregnant at time of death 1 Yes 2 No 9 Unknown	5 Other (Specify)		
Ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be refeath. retor. After this certificate has been signed by the attending physici by the functal director, page 2 should be deached for use as the built be deathed for use as the built be deathed for use as the purification.		ng in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
P.O. ires that signed by the deta	6		1 Yes 2	2 No 3 Probably 4 Unknown
ords, law requir has been s			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
tal Reco			performe 1 Yes 2	
tal F	25. Was case referred to medical	26.Place of Death (Che		sidence 6 V Other: Scene
n of Vital I ling Physician: After this certificaneral director,	O 1 V Yes 2 No 1 inpatient 2 Error	Outpatient 3 DOA Outlet 4 Nu Time of Injury 28c. Injury at Work?	rsing Home 5 Res	
Sion C Attending death. crtor: Aft	1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2 No		
> 5 4 5 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 X Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, (Specify)	farm, street, factory, office building, etc.	28f. Location (Stre or Town, State	set and Number or Rural Route Number, City e)
	To Certifying Physician: To the best of my knowledge, do not one one of the control of the basis of examination and/or	eath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the cause(s ed at the time, date and	i) and manner as stated. d place, and due to the cause(s)
To with	29b. Signature and title of certifier	29c. License number		9d. Date signed (Month, Day, Year)
,	July Valley Jel	O.C.M.E.	(October 29, 2009
Ø	30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner	111 Penn Street, Baltimore, M	1D 21201	
Sta				
Registra	MUY O BOOK / LINE J. D.	RIGINAL		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 25. Frank Krofka 3:40 P.M John Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ellicott City Health & Rehab Ellicott City Howard If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 😾 M 2 🗆 F July 18, 1920 New York Hours 89 Director 060-16-4728 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Newark Worcester 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ŏ raf", or items 23a o Examiner must be Funeral U.S.A. 8505 Newark Road 21841 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes. Give Year or Dates. 42-43 "natural" 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Disability Reviewer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ရ Agnes Grabias John Krofka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a William Krofka / Son 8505 Newark Road Newark, MD 21841 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: It any injury or 4 ☐ Donation 5 ☐ Other (Specify) Maple Grove Cemetery: 10-30-2009 Frewsburg, NY 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave. Catonsville, MD 21228 Signature of Funeral Ser LIC # Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOJALMONARY Pnysician ARREST disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner DISEASE RONARY Sequentially list conditions, il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, HYPERTENSION and burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 1 Yes 2 No ed by the a detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, ALZITEIMER'S DEVENTIA 1 Yes 2 No 3 Probably 4 Unknown Completed peen ARTHRITIS 24b. Were autopsy findings available prior to completion of cause of OSTEO 24a. Was an has autopsy performed Yes 2 certificate 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 M No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours a er dearh.

To the Funeral Director After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or win 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 271 30469 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. B. VELLANK, 8850, COLUMBIA 10 BARKWAY: #308 Columbia, MD. 21045

Registrar

State

N.B. VELLANKI, 31. Date filed (Month, Day, Year)

MON A 3 SOMA

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** George Michael Kessel October 29 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agnes stmore Hospaal If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1⊠M 2□F 137-18-8131 April 17, Director 87 1922 New Jersey Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Evaniner must be notified at 1 ☐ Yes 2 X No Director MDBaltimore Catonsville Pages 1 and 2 should be filed within 72 hours after death with the I nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1200 Cedar Circle Court 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed by 3 X Widowed 4 ☐ Divorced Year or Dates: WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Life Insurance Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNK UNK ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James B. Gillespie Nephew 28 Dover Avenue; Berlin, NJ 08009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any Injury or o 1I☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Saviour Cemetery 11/4/2009 Bethlehem, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke LIC # 21. Signature of Euro Funeral Home of Catonsville, Inc. MO1537 1630 Edmondson Avenue; Catonsville, MD 21228 Part 1. Enter the disease, or complications that caused tr shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** ev alon resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): 68760. physician Physician/Medical the as IF FEMALE: nse 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy detached for Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 2 No 1 TYes 1 ☐ Yes Hospital or Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Impatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours atter death. To the Funeral Director: # 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) (26 U 201) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 6:30AM Larreo 2009 Angel Sister Mary 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore 701 Gun Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. Months 1 □ M 2 🖫 F 91 Cuban 31 18 05 212-58-7871 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1X Yes 2 □ No Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21227 U.S.A. 701 Gun Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Myes 2 No Specify: Cuban Specify: Hispanic 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) School Teacher 5yrs 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maria J. Dihigo Pedro J. Larreo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 701 Gun Road, Baltimore, Md 21227 Sister Clarice Proctor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1√ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/6/09 Baltimore, Md Loudon Park 22. Name and Address of Facility March F/H West 21. Signature of Funeral Service Ligenses Md 21215 Baltimore, 4300 Wabash Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final erebrovascular wee disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 2 3 0 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work?

ivision of Vital Records, P.O. Box 68760, Larrea - Dihia After this death. after death Director:

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a To the Funeral C

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

Director

Funeral

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Completed

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Physician/Medical

Completed by

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Certification: To

Medical

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Evanthor must be notified at once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 5 ☐ Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

(Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ender Ave Baltzm MCNESNE atthew

31. Date filed (Month, Day, Year) State 3 2009

32. Registrar's Signature

Registrar

09-08300 Zv'naire Lane Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No. Registrar 3. Time of Death Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 25, 2009 0525 hrs Zy'naire Medical Examiner Lane 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Hospital If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Foreign Days Months Hours Min. Director 214-85-5357 1 M 2 X F 28 09 MD Yrs 05 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County X Yes 2 No 28a-f show NA Baltimore or other traumatic event, the Medical Examiner must be notified at once. MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21213 3434 Elmley Ave items 23a or 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes Black Specify f Yes, Give Year Yes 2 X No specify: Divorced Widowed ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 721 Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene.
ant: If item 27 is marked other than N/A Baltimore, MD 21215-0036 N/A N/A N/A 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Londra Carter Be Rodney Lane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3434 Elmley Ave, Baltimore, Md 21213 Londra Carter-Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State partment or 11/2/09 Woodlawn, Md Memorial Park Kina Donation 5 Other Specify 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee Baltimore, 21215 4300 Wabash Ave, an Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Acute and chronic aspiration pneumonia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical AMENDED 23a,27,permE, g899 1/15/10 tt **X** UNPENDED ned by the attending physician detached for use as the burial The law requires that the death certificate be Box 68760, 23d Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) Yes 2 ✔ No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Yes 2 No 3 Probably 4 🗸 Unknown þ Completed 24b. Were autopsy findings available certificate has been sector, page 2 should 24a. Was an prior to completion of cause of autopsy death? performed? 2 No ✓ Yes 2 No 1 V Yes 26.Place of Death (Check only one) After this certific funeral director, 1 Hospital or Attending Physician: 124 hours after death. 25. Was case referred to medica Be Other₄ examiner? Hospital: 2 FR/Outpatient 3 Nursing Home 5 Residence 6 Other Innatient 1 🗸 Yes No ဂ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 27. Manner of Death X Natural Yes 2 e Funeral Director: A Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 26, 2009 O.C.M.E 1 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant/Medical Examiner Russell Alexander MD. 31. Date filed (Month, Day, Year State

Registra

		1	State of Maryland / Der State of Maryland / Der State Registrar	partment of Health and Nertificate of Death	Mental Hygiene Reg. No.	2009 35236
	Physicia		Decedent's Name (First, Middle, Last)		2. Date of Death 1 Month 2 Day	3. Time of Death 3:45 Рм
ر ر	Medic Examin	al er	William H. Lowrey 4a. Facility Name (if not institution, give street and number) Gilchrist Center	4b. City, Town, or Location of Death Towson	4c. C	County of Death timore
	Funeral Director		5. Social Security Number 6. Sex 1215-28-5997 7. Age Jayrs. last birthday 12 F 7. Age Jayrs. last birthday 12 F 7. Age Jayrs. last birthday 15. Social Security Number 15. Social Secur	y If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 9 / 25 / 1930	9. Birthplace (State or Foreign Country) Mary Land
			Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	e Maryl r 28a-f notifie	լ.≃ ւ	MD Howard Mount Air	y 10f. Zip Code	10g Citiz	1 ☐ Yes 2 🛣 No ten of What Country?
	with the 23a of	eral I	1022 St. Michaels Rd	21771		ed States
980	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	[출	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto □ Yes 2√√xNo Specify:	Rican, etc.)	4. Race - American Indian, Black, White, etc. Specify: White
15-0	72 hou 1 "natı ledical	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of work DO NOT use retired)	ing 16b. Kin	nd of Business Industry
21215-0036	within giene. er thar the M		Flamonton/Cocondoy (0.12) College (1-4 or 5+)	tant Manager of B	ntance '	ard County Schools
pue	ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last) Charles William Lowrey	18. Mother's Nam	ne (First, Middle, Maiden Si E. Cavey	urname)
Maryland	should b and Mer is mark sumation		19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Rur St. Michaels Rd.		Town, State, Zip Code)
e, N	and 2 s Health em 27 ther tra			sposition (Name of		cation - City or Town, State
mor	Page 1		XIX Purisi 2 Compation 2 Permayal from State cemetery, o	rematory or other place) prings Cem 11/5/		ar Springs, MD
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot		21. Signature of Funeral S. V. Licensee	22. Name and Address of Facility Urrier-Queen Funer 212 W. Old Liberty	al Home and Rd. Winfie	Crematory, P.A. ld, MD 21784
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
Z	Physician Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	elmenta		years
	Examiner	Ļ	Sequentially list conditions, b.			
	ed sit	Examine	if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury)			
M.	execute an and rial-tran	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
09/	ate be physici the bu	edica	d			
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical		3		23d. Date of delivery Month Day Year
s, P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		se contribute to the cause of death?
Record	The law requisate has been page 2 should	Completed by			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
ita	nysician: The nis certificate I director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpo	26. Place of Death (Chec		N Other (Specify) hospice
of V	ding Phys h. After this funeral di	te: To	27. Manner of Death 28a. Date of injury 28b. Tim	e of 28c. Injury at	lome 5 Residence 6, 28d. Describe how injury	
ion	ttending death. :tor: After / the funer	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	28f Location (Street and	Number or Rural Route Number,
Divis	tal or Attend s after death al Director; A ed in by the f		4 Homicide determined building, etc. (Specify)	Street, ruesary, amee	City or Town, State)	
	To the Hospital or within 24 hours afte To the Funeral Dir completed filled in	Medical	29a. Certifier (Check (Check only one) 1 Certifying Physician: To the best of my knowledge, dea	vestigation, in my opinion, death occurred	at the time, date and place,	and due to the cause(s) and manner stated.
•	To the within comp		29b. Signature and title of certifier Lat CRNP	29c. License number		e signed (Month, Day, Year)
	8		30. Name and address of person who completed cause of death (Item 23a) (Type War on Grant, G701 N. (Lo	e, Print) sus, Towson, V	ND 2120	94
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registr	rar	NUV - 3 ZUUS Berling A.	<u> </u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

awara Lauriop		- For State Registrar		cate of Dea			1. No. 200	9 3523
Physici	an/	1. Decedent's Name (First, Middle,Last)				Date of Death Month	Day Year	3. Time of Death 0719 hrs
ledical Exami	ner	Edward Lathrop, Ir. 4a. Facility Name (if not institution, give street and nu		Ab Cia	Town, or Location of De	October 27	, 2009 4c. County of Death	
,		4a. Facility Name (if not institution, give street and nu 6703 Rapid Water Way	mber)	,	, Town, or Eccation of De n Burnie	adu i	Anne Arundel	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	irthday) If Ui	nder 1 Year If Under 24	Hrs. 8. Date of Birtl	(MM/DD/YYYY) 9. Bir	
Director		216-50-0199 1XM 2F	62	Yrs. Mor	ths Days Hours	Sept. 2	Foreig 2, 1947	untry)Maryland
any	ı	10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
Aaryland 28a-f show 1 at once,	اة	Maryland Anne Arundel	Glen	Burnie				1 Yes 2 X No
th the Maryland 23a or 28a-f sho	Director	10e. Street and Number		10f. 2	Zip Code	10	g. Citizen of What Coul	ntry?
th the 23a or		6703 Rapid Water Way			21060		Jnited Stat	es can Indian, Black,
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygener 7 is marked other than "natural", or items 23a or 28a-f 5he marie event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 X Married Armed F	2 No		dent of Hispanic Origin? ecify Cuban, Mexican, Pu		White, etc.	can mulan, black,
hours after 'natural'', Examiner i	ğ	3 Widowed 4 Divorced If Yes, Give Yes or Dates:			2 X No specify: al Decupation (Give kind	Lefwork done	Specify: Wh	ite
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygene. Important: If item 27 is marked other than injury or other traumantic event, the Medical	욘	19a. informant's Name/Relationship (Type, Print) Jovce Lathrop / Wife	91		id Water Wa		Burnie, MD	21060
e, N l and 2 Health item 2		20a. Method of Disposition	20b. Place	e of Disposition (I	Name of cemetery,	Date	20c. Location - City or	
Baltimore, permit. Pages I as Department of He Important: If ite		Burial 2 X Cremation 3 Removal f Donation 5 other Specify:	OIII State	natory or other pla		0/30/2009	Catonsvill	e, Maryland
altir mit. 1 partm porta ury o		21. Si pature of uneral Service Licensee	/	22, Name a	nd Address of Facility ey-Ruddick	Funeral H	ome. P.A.	07 1142 7 24114
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3876 rtifical ling ph		23b. Was decedent pregnant in the nast 12 months?	birth	2 Fetal dea	ath 3 Ectopic p	regnancy	Month	Day Year
Box 687 ne death certific the attending p	Physician/	1 Yes 2 No 9 Unknown 9 Unkr	nant at time of death	5 Other (S	Specify)			
Ç ₽ ₽ ₽	Phy	Part II. Other significant conditions contributing		ting in the underly	ring cause given in Part I	. 23e. Did to	bacco use contribute to	the cause of death?
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Fo the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis and manner	of examination and/o stated.	or investigation, in		rred at the time, date		
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7) (my me, or	>,		O.C.M.E.		October 20, 200	
ex stad	ľ	 Name and address of person who completed car Ling Li, MD Assistant Medical Exa 			altimore, MD 2120	1		
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	rylanc show	_	10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits	
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215-0036	within 72 hours after death with the Marylan liene. then 'natural', or items 23a or 28a-f show the fire field Eva. it are must be calified at	b	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Date:	No		Tes, specify Cub □Yes 2 XINo			ari, etc.)		Black, White Specify: Wh	•
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	should be and Ments marked martic ev	으	Thomas Alvin Doerer, Sr.					na Loui				
	S S S		19a. Informant's Name/Relationship (Type. Print)							-	or Town, State, 2	Zip Code)
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Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Fun in Service License Michael Flag	Te	22. Le	Name and Addre	ess of Fac nera	1 Home	of Dul	lane	ey Valle , MD 210	y, Inc.
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State of Maryland / Department of Health and Mental Hygiene 19

35239 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Day Physician 9:55AM herino 10 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number old court Birthplace (State or Foreign Country) 7. Age (In vrs. **Funeral** Days 1 M 20 219-34-0055 80 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar is use the notified at 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 1 ☐ Yes 2 No Reisterstown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2→No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Whil þ 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LINE UNK LNK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WNK ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Chesser Ms WSON 1912. worker WTRA 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Balt-MO Hudson St. 4 □ Donation 5 □ Other (Specify) 11-2-09 Cemelary Mi Carnel 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 21274 T. Scarda FH 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic distr /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 1 ☐ Yes 2 No 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ₫ 1 | Yes 2 | No 3 | Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 2/2 No 1 □Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 1 Matural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 411 30. Name and address of person who completed cause of death (I em 23a) (Type, Print) A 413 commo 31. Date filed (Month, Day, 32. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001 09-07441 Roy Mason

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 35240 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Y September 22, 2009 Medical Examiner 1935 hrs Roy Mason 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State of Foreign Country) Washington 5. Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) Hours Months Days Director 1 XM 2 577-17-2447 20 11/13/1988 DC Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1X Yes 2 No 28a-f shov Baltimore Director 10e. Street and Number 10g. Citizen of What Country? Examiner must be notified at 10f. Zip Code items 23a or 334 Holy Cross Rd U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 X Never Married 2 Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Married Yes 2 X No f Yes, Give Year Widowed Divorced Yes 2X No specify: Specify: Black à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry UNKNOWN Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "1 tant: If item 27 is marked other than or other traumatic event, the Medical Baltimore, MD 21215-0036 Trans. 12th 17, Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Satre Mason Be Roy T. Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Satre Mason/ Mother 519 N. Holland Baltimore, MD 21205 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 crematory or other place) Removal from State Donation 5 Trinity Other Specify: Cemetery 10/2/09 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Skarda Funeral Home 2829 Hudson St. Baltimore, Part I. Enter the disease, or condications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Cardiac arrhythmia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) b. Dysplasia of the myocardial nodal arteries Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and Physician/Medical the attending physician and for use as the burial -X UNPENDED AMENDED PI line a-b, 27, per ME g897 11/10/09 TT the Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live hirth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown e has been signed by the 2 should be detacher 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ੬ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 No ✓ Yes 2 No 25. Was case referred to medical Division of Vital 26.Place of Death (Check only one) Be examiner? Other 4 this Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ဥ 1 V Yes No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 X Natural Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 23, 2009 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Mon Registrar's Signatu State arked Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 3524 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Genevieve McCloskey 2009 1:36 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brightview Assisted Living Catonsville Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland 1 □ M 2 🖺 F Months Hours Min. March 29, 1926 83 217-20-2831 Director Yrs Usual Residence of Decedent Fage 1 and 2 should be filed within 72 hours and 2 should be filed within 72 hours and 2 should be filed within and Mental Hygiene, then "natural", or items 23a or 28a-f show reart; if item 27 is marked other than "natural", or items 23a or 28a-f show reart; if item 27 is marked other than "natural", or items 23a or 28a-f show reart. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? Funeral 3133 Greenway Drive 21042 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc 1 Never Married 2 Married 2 Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White If Yes Give 3 ₩ Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Catholic Charities Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Salvatore Papa Josephine Alasha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen McCloskey, Son 3133 Greenway Drive Ellicott City, Maryland 21042 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Department of Important; If any injury or 10/31/09 New Cathedral Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor 2MacNabod Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ementia disease or condition resulting in death) mer's Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? ō Month Day Year Pregnant at time of death the Unknown g Unknown sate has been signed by page 2 should be detact Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ the Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 1 Yes 2 No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? ASSISTED Hospital 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this d in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at iniury work?
1 Yes 2 No 5 Pending within 24 hours after death.

To the Funeral Director: After completed filled in by the functions. Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Dear

0 3 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11M

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32. Registrar's S

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n Stree

29c. License number

XXX53337

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			Registrar		Cer	lilicate of L	Jeaur		Reg. No.	U.A.	33246
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	Examin		4a. Facility Name (if not institution, give s	treet and number)		4b. City, Town, or	r Location of Death		4c. County o		
			1937 Guy Way			Dun	dalk		Ba1	timo	re Co.
	Funeral		5. Social Security Number 6. Sex	1	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	th v Voort		lace (State or Foreign
	Director		347-34-9221	M 2 □ F 67	Yrs.	IVIOITIIS Days	Flours Will.	April 2	29, 1942	Counti	" Illinois
	d ow	L	Usual Residence of Decedent 10a. State 10b. County	100 0	ty, Town or Loc	cation				10	Od. Inside City Limits
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	th th 3a o	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of 1304 Broening Highway 21224 Unit								
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<u>ya</u>	ld be Ment arke	욘	Carlous James Mo	ore, Sr.			Geral	ldine P.	Brown		
<u>a</u>	shou and is m		19a. Informant's Name/Relationship (Typ					ral Route Numbe	r, City or Town, Sta re, Mary	ate, Zip C	ode) 21224
~	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. ittem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Bettyann T. Moor			4 Broeni	ng nwy.				
ore			20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ F		Place of Dispo cemetery, cren	sition (Name of natory or other plac		Date	20c. Location - 0	•	
<u>E</u>	: Page 1 tment of 1 tant: If it jury or o		4 ☐ Donation 5 ☐ Other (Specify)	Oa1		Cemetery		31/2009			Maryland
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	е	$D_{\mathbf{U}}^{22}$	Name and Address da-Ruck	ss of Facility Funeral	Home of	Dundalk,	Inc	• • • • • • • • • • • • • • • • • • • •
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	endir r use	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnation 1 ☐ Live Birth 2 ☐ Fet	ancy aldeath 3 □	Ectopic pregnanc	су		23d. Date		
Box	deatl	sici	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5	Other (specify)			Mon	th	Day Year
P. O.	t the by the	Ph	Part II. Other significant conditions cor	stributing to dooth but not ro	oulting in the u	andorlying course di	von in Part i	00- Bid to			a serves of death?
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<u> </u>	Physic this cal dir	은 ::	1 ☐ Yes 2 No 27. Manger of Death	1 Inpatient 2 I	ER/Outpatier 28b. Time of	nt 3 🗆 DOA	4 LJ Nursing F				Residence
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210	deat ctor: y the	l≝	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome farm stre		TIES Z L INO	28f Location (S	Street and Number	or Rural	Route Number
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for completed filled in by the funeral director, page 2 should be detached for		4 ☐ Homicide determined	building, etc. (Specif				City or Tow			
_	Hospi	Medical	(Check 2 Medical Examin	cian: To the best of my know er: On the basis of examination	on and/or invest	tigation, in my opinio	on, death occurred	at the time, date a	and place, and due	to the cau	ise(s) and manner stated
	the the sumple	Ž	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practioner: To the best of m	ny knowledge, o	death occurred at the	ne time, date and pla	ace, and due to th	e cause(s) and mar 29d. Date signed	ner as sta	ated.
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	,		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type F	Print)			101		
			C. DE C. C.	NeWlack	1001	N. Pa	A Bly	d Bo	it is	1,5	NO 2122
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 46 AM **Physician** Day Year Flora Bell Martin Jovember 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Town, or Location of Death If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Feb. 9, 1921 9. Birthplace Country) West 5. Social Security Number If Under 1 Year Funeral Months Days 1 □ M 2X F 212 46 1558 Director 88 Virginia Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Madical Experimer must be notified at once. Maryland Baltimore Director 1 ☐Yes 2X No Essex 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 342 Upper Landing Rd. 21221 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cobbler Shoe Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Sparks Luellen Baldwin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Wronowski (Daughter) 922 Candlelight Ct. Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State Gardens Of Faith Cemetery 11/4/2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses Bruzdzinski Funeral Home P.A. W 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** nar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No signed by the a Ö 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s was ...
autopsy
performed?
Yes 2 X No certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes of Vital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To After this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 82. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			For State	State of Marylan				Mental Hyg	jiene	
			Registrar 1. Decedent's Name (First, Middle, Las	t)	Cer	tificate of	Death	T-	Reg. No. 2009	35244
	Physicia Medic			Raymond Ma	tthew	Miller,	Jr.	2. Date of Dea Month October	Day Year	3. Time of Death 4:00 PM
	Examin	er	4a. Facility Name (if not institution, give			-	or Location of Death	n	4c. County of Deati	
	Funeral		1807 West Avenu 5. Social Security Number 16. Se		st birthdav)	Dur If Under 1 Year	ndalk I If Under 24 Hrs.	8. Date of Birth	Baltimo	hplace (State or Foreign
	Director			M 2 □ F 87	Yrs.	Months Days	Hours Min.	(Month, Day		ryland
	mo n		Usual Residence of Decedent 10a. State 10b. County	140.00	, Town or Lo					
	arylan a-f sh fied a	Director			, TOWIT OF LO					10d. Inside City Limits 1 ☐ Yes ※XX No
	he Ma	Dire	Maryland Bal 10e. Street and Number	timore		Dunc 10f, Zip Code	lalk		10g. Citizen of What Co	
	with t	era	1807 West Aven	ue			2122	1	United Sta	
	leath items ier mi	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13. V	Vas Decedent of F	lispanic Origin? (Span, Mexican, Puerto		14. Race - Amer	ican Indian,
36	after o	by	1 Never Married 2 Married	1 tv Yes 2 □ No If Yes, Give	1	Yes 2 No		o rilean, etc.)	Black, White Specify:	, etc.
Ş	ours atural	Completed	3 🔀 Widowed 4 🗆 Divorced	Year or Dates. WWLL		lent's Usual Occup			W	hite
715	an "ni Me Ji	mpl	(Specify only highest gra Elementary/Seconday (0-12)	de completed) College (1-4 or 5+)	(Give I	kind of work done O NOT use retired,	during most of wor	king	16b. Kind of Business I	ndustry
212	withii giene er th		12 Years	1 Yr.	Μe	at Sales	man		Armour Mea	t Company
pu	a filed tal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)					me (First, Middle, I	,	•
7	uld bu d Men marke natic		Raymond Matthe		1		· · · · · · · · · · · · · · · · · · ·	se Dettm		
Ma	2 sho Ith an 27 is 1		19a. Informant's Name/Relationship (Ty Mrs. Barbara Lo			•	and Number or Ru renue Du		City or Town, State, Zip ${ t arvland} \hspace{0.1in} 21$	222
re,	1 and of Hea item		20a. Method of Disposition	20b. P	ace of Dispo	sition (Name of	!	Date	20c. Location - City or	Town, State
Ē	Page nent d ant: If ury or		1 Denstion → □ Cremation 3 □ 4 □ Denstion → □ Other (Specif			natory or other pla Cemetery		29/2009	Baltimore,	Maryland
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Me Ical Examiner must be notified at once.	6 99	21. Signature Ineral Service Lice	V. Dash	22	Name and Addre	ss of Facility Funeral	Home of	Dundalk, I	nc.
			23a. Part 1. Enter the disease, or comp	lications that caused the death			Ave. Di			1222 Approximate
	Physician/		shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line.	BRO	NARY	HRTI	ony D	ISPASE	Interval Between Onset and Death
	Medical Examiner		resulting in death)	a. Due to (or as a consequ	ence of): 11	Votro-	TAIS 10	11	47.0	
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	ence of	11th	TENSIO	110		
	ted I Insit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequ	erice orj.	ASTI	MA			
	execu an and rial-tra	Ex	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					
09	cate be executed physician and s the burial-transit	dical		d						
687	ertifica ding p	/Me	IF FEMALE:	23c. If yes, outcome of pregnar	ncv					
Box 687	eath certifica attending p	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Fetal 4 Pregnant at time of d	death 3	Ectopic pregnan Other (specify)	су		23d. Date of deli Month	very Day Year
В	the de by the ached	Physician/Me	9 Unknown	9 Unknown						
P.O.	ires that the dea signed by the a Id be detached f	٦	Part II. Other significant conditions co	entributing to death but not resu	ılting in the u	nderlying cause gi	ven in Part I.		bacco use contribute to	
rds	require been si should I	eted						1 L Y		obably 4 Unknown
900	has b	Completed						24a. Was a autop perfor	sy prior to c	opsy findings available ompletion of cause of
m m	s ician: The law r certificate has b lirector, page 2 s		25. Was case referred to medical			00.5	lana of Danah (Oha	1 🗆 Yes		2 🗆 No
Vita	ystcia s cert	To Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ I	EB/Outpatien	LOth	lace of Death (Chec		ence 6 🗆 Other (Speci	64
of	ng Phy ter thii neral o		27. Manner of Death		28b. Time of injury	28c. Injur	y at	T T	ow injury occurred	(9)
on	tendir leath. or: Af the ful	ifica	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		injury		Yes 2 ☐ No			
Division of Vital Records,	I or Attending Physician: The la after death. Director. After this certificate ha I in by the funeral director, page	Certificate:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (Si City or Town	reet and Number or Run n, State)	al Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Exami	icfan: To the best of my knowle ner: On the basis of examination	edge, death o	occured at the time	e, date and place, a	and due to the cau	se(s) and manner as sta	ted.
	the Fithin 24	Me	only one) 3 Certifying Nurs 29b. Signature and time of certifier /	e Practioner: To the best of my	knowledge, c	leath occurred at the	ne time, date and pla	ace, and due to the	cause(s) and manner as	stated.
	5.≱ 5.8		250. Signature and the of certifier	Kally MO		29c. Licens	ANT74	(90)	29d. Date signed Month	Day, Year)
	(VA)		30. Name and address of person who c	pmpleted cause of death (Item	23a) (Type, P	rint)	207/0	10	UUGU	20,200
	Stat	0	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	0	1207	Tart	ROM	CYTHER	WILLE, MD
	Registra	ır	NOV - 3 2009	A. A.	A	-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		- For State legistrar	Cert	ificate of	Death			. No. 2	109 3524
Physician/ dical Examine		Decedent's Name (First, Middle,Last)	Dennis	McLaug	ghlin		2. Date of Death Month October 30	Day Year , 2009	3. Time of Death 1325 hrs
	4	4a. Facility Name (if not institution, give st Johns Hopkins Hospital Bay		4	b. City, Town, or I Baltimore	ocation of Death		4c. County of D	eath I / A
Funeral Director		5. Social Security Number 6. Sex 120-64-5209	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days			(MM/DD/YYYY) 9	Birthplace (State or or oreign Country) MD
nd show any ce.	Ī		imore 10c. City, 7	Town or Location	Dunda				10d. Inside City Limits 1 Yes 2 XXNo
with the Maryland ns 23a or 28a-f show be re-diffed at once.	Ulrect	10e. Street and Number 1701 Park Drive	111010		10f. Zip Code	212	1	g. Citizen of What United	
or death with or items 23 r must br mer Funeral	Funeral	1 Never Married 2 X Married	2. Was Decedent Ever in U.S Armed Forces?	If Y∈	S Decedent of Hises, specify Cuban	, Mexican, Puerto		14. Race - A White, e	unerican Indian, Black, tc. White
72 hours after n "natural" al Examine	ਠ⊦	3 Widowed 4 Divorced If 15. Decedent's Education (Specify only Elementary/Secondary (0-12)	r Dates:	16a. Decedent during mo	's Usual Occupat ost of working life.	ion (Give kind of v DO NOT use reti	red)	16b. Kind of Busin	ess/Industry
215-0036 be filed within 72 hour ntal Hygiene. ked other than "natu ent, he Medical Exa		12 Years 17. Father's Name (First, Middle, Last)		Owner	of Bil	18.Mother's Name	(First, Middle, M	,	ards
MD 2121 d 2 should be fil lth and Mental F n 27 is marked aumatic event,		Kenneth F. McLau 19a. Informant's Name/Relationship (Type Mrs. Sharon J. Mc	e, Print)		Address (Stree	t and Number or I		Muth per, City or Town, S Maryland	State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be ne-diffed at once To Be Completed by Funeral Director	- 18	20a. Method of Disposition 1 Burial 2 Cremation 3 2 Donation 5 Other Specify:	Removal from State	Place of Disposi rematory or oth	ition (Name of cer ner place) Service	Corp. 11	Date /3/2009	20c. Location - City or Town, State Towson, Maryland	
Baltin permit. Departm Importa injury of	Î	2 Signature of Funeral Social License		22. N	ame and Address Ouda-Ruc 7922 Wis	of Facility k Funera se Ave.	l Home o Dundalk	of Dundal , Maryla	k, Inc. nd 21222
Physician /Medical xaminer	1		ations that caused the death. line. ontact Gunshot Wound e to (or as a consequence of	d of Head	ne mode of dying,	such as cardiac o	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
iner	ıner	Sequentially list conditions, if any, leading to immediate Ducceuse Error Underlying Course	e to (or as a consequence of						
60, ate be executed thysician and e burial - transit	al Exan	events resulting in death) Last Du							
Records, P.O. Box 68760, The law requires that the death certificate be executed ricate has been signed by the attending physician and page 2 should be detached for use as the burial - transitional by Physician/Medical F.	n/Medical	IF FEMALE:	23c. If yes, outcome of pregnancy 23d. Date of delivery edent pregnant in the 1 Live high a Fetal death 3 Ectopic pregnancy Month Day Ye						
Box 6876 The death certificate The attending phy The dfor use as the beat for use a	≥ا	past 12 months? 1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown Part II. Other significant conditions. contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of							
rds, P.O. requires that the been signed by hould be detached by the best by th	2	Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	inderlying cause (given in Part I.		2 V No 3	
of Vital Records, ag Physician: The law requir offer this certificate has been s meral director, page 2 should	Completed		autop: perfor 1 V Yes	autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 No 249. Were autopsy intolligs available prior to completion of cause of death?					
Vital Rec hysician: The I this certificate I I director, page	ŭΙ	25. Was case referred to medical examiner?	spital: 1 Inpatient 2	ER/Outpatient		Other Nursi		Residence 6	Other:
- = ^ = I a	1 V Yes 2 No 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred								
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the funeral Certification	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined Coperation Specify Office 4 Homicide Accident Investigation See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number or Town, State) 7215 Rolling Mill Road, Dundalk, MD							alk , MD
	edical	one) Medical Examiner: C	a: To the best of my knowledge on the basis of examination are and manner stated.	ge, death occur nd/or investigat	red at the time, d tion, in my opinior 29c. Licens	n, death occurred	d due to the caus at the time, date	and place, and due	s stated. e to the cause(s) I (Month, Day, Year)
		30 Napre and address of person who co	mpleted cause of death (Item	23a)	0.C.	M.E.		October 31,	2009
		Laron Locke MD. Assista	nt Medical Examiner	111 Penr	Street, Balti	more, MD 21	201		
	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire.					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35246 State of Maryland / Department of Health and Mental Hygiene 19 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:38 P M 30, October 2009 Helen Ruth Moody /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Be1 Air Upper Chesapeake Health If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🖫 F Yrs. 12,1935 West Virginia 74 Director 216-32-3489 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Edgewood Directo Harford Maryland | 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21040 by Funeral 2046 Kenny Court 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Physics Lab Johns Hopkins University 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lelia Whitecotton Herbert Montgomery ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edgewood, Maryland 2046 Kenny Court Mr. Robert L. Moody (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Baltimore, Maryland 1 □ Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith Cem. 11/4/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura Juneral Service Licensee 22. Name and Address of Facility al Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear realiure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Due to (or as a consequence of): Physician/Medical IE EEMALE 23d. Date of delivery yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Year Month Day 5 Other (specify) Tyes 2 PNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Pres 2 No 3 Probably 4 Unknown Completed ticoagulat 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 2 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 **⊟** No ဥ 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Medical Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide

Examiner Records, P.O. Box 68760, 30509

death with the Maryland

s 1 and 2 should be filed wrum.

Baltimore, Maryland

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event,

or than "natural", or items 23a or 28a-f show

led by the attending physician and detached for use as the burial-tran signed by t has been certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

> State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certified

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 13a) (Type, Print) man co

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month, Day, Year) egistrar's Signa

09-08260 John McDowell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ohn McDowell	State of Maryland / Department 1- For State Certificate		2007 3324
Physician ledical Examine	1. Decedent's Name (First, Middle,Last)	2. Date of Month	Day Year 1222 hrs
edical Examine	4a. Facility Name (if not institution, give street and number) Johns Hopkins Bayview Medical Center	Oowe11 Octob 4b. City, Town, or Location of Death Baltimore	dc. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8, Date	e of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Ly 29,1987 Country) Maryland
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo		10d. Inside City Limits
* .	Maryland N/A	Baltimore City	1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number 312 South Robinson Street	10f. Zip Code 21224	United States
15-0036 Hygiene. d other than "natural", or items 23a or 28a-f sh. the Medical Examiner must be notified at once	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et	white, etc.
hours after "natural", c	3 Widowed 4 Divorced In Yes, Give Year 1	Yes 2 X No specify: dent's Usual Occupation (Give kind of work done	Specify: White 16b. Kind of Business/Industry
21215-0036 and be filed within 72 hours a Mental Hygiene. marked other than "natura cevent, the Medical Examin	Elementary/Secondary (0-12) College (1-4 or 5+) P1	g most of working life. DO NOT use retired) umber Apprentice	Plumbing
21215-0036 Juld be filed within 7 Mental Hygiene. Marked other than to event, the Medica	17. Father's Name (First, Middle, Last) John McDowell, Sr.	18.Mother's Name (First, M Ann Mari	
AD 212 2 should b h and Meni 27 is marl tmatic ever	19a. Informant's Name/Relationship (Type, Print)	iling Address (Street and Number or Rural Rou	ute Number, City or Town, State, Zip Code) Baltimore, Maryland 2122
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 nt of Health and Mental Hygene. it: If item 27 is marked other than other traumatic event, the Medical	20a. Method of Disposition 20b. Place of Disposition 3 Removal from State crematory of	position (Name of cemetery, Date r other place)	20c. Location - City or Town, State
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: If iten 27 is or injury or other traumatic.	4 Donation 5 Other Specify: H1111CO	p Service Corp. 10/29 2 Name and Address of Facility Duda-Ruck Funeral Home	e of Dundalk, Inc.
Physician	23. Fart I. Enter the disease, or complications that coused the death. Do not en	7922 Wise Ave. Dunda er the mode of dying, such as cardiac or respirat	1k, Maryland 21222 tory arrest, shock, or heart Approximate Interval Between Onset and
/Medical xaminer	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	tion	Death
	Sequentially list conditions, b		
e it	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		
0, be executed sician and burial - transit	0	f, per ME G898 12/4/09) TT
6876 certificate nding phy	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery Month Day Year
t the death by the att	7 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in		e. Did tobacco use contribute to the cause of death?
ires that the signed by	à l		Yes 2 ✓ No 3 Probably 4 Unknown
Civision of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hour after death. To the Funeral Director: After this certificate has been signed by the attention of the funeral director, page 2 should be detached for use the funeral director, page 2 should be detached for the funeral director.	Completed		a. Was an autopsy autopsy findings available prior to completion of cause of death? ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Reorganica The Inis certificate director, page	25. Was case referred to medical	26.Place of Death (Check only one tient 3 DOA Other Nursing Home	
n of Vi	O 1 Yes 2 No Impatient 2 V Ervoupa	of Injury 28c. Injury at Work? 28d. De	escribe how injury occurred
Jivisio	2 Accident Investigation 3 Suicide 6 Could not be determined (Specific) hours of	2:00 ptn street, factory, office building, etc. 28f. Lo	cation (Street and Number or Rural Route Number, City Town, State) D Lakeview Ave. Edgemere.
Civision To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	To Certifying Physician: To the best of my knowledge, death of (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation.	occurred at the time, date and place, and due to t	the cause(s) and manner as stated.
To To Com	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	30. Name an address of person who completed cause of death (Item 23a)	O.C.M.E.	October 25, 2009
		1 Penn Street, Baltimore, MD 21201	
Sta Registr		alla	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Beverly Elizabeth Miller 2009 4:15 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 □ M 2**XX**F Days Hours (Month, Day, Year) **Director** 220-50-1692 May 1946 Maryland Usual Residence of Decedent or 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Rosedale 1 Yes X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5811 Westwood Avenue 21206 USA 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force 1 Never Married 2 X Married þ Yes 2 No 5-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: Completed 3 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 11 Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Earl Montgomery Hazel Wolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald R. Miller, Sr. Husband 5811 Westwood Avenue, Rosedale, Maryland 21206 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park 11/04/2009 Woodlawn, Mary; and 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign tur Funeral Service Licensee Burgee-Henss-Seitz Funeral Home, Inc. 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

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Appr Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Directo for esle consequence of if any leading to ke medicause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant a 9 ☐ Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 s autopsy performe 2 🗌 No 1 \sum Yes Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify HOS / မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work n 24 hours after death.

e Funeral Director: A pleted filled in by the fu Accident 1 Yes 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29d. Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print) 230 31. Date filed (Month, Day, Ye

State Registrar

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 200⁹gar 1:45 P.M Thomas Joseph McKeon Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nov. | Days | Hours | Min. | Nov. | Day, Year | 1918 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 🖾 M 2 🗆 F New Jersey Director 136-12-5813 90 Yrs Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits MD Baltimore Catonsville 1 🗆 Yes 2 🎦 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Completed by Funeral 715 Maiden Choice Lane 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 0. Black, White, etc. 1 ☐ Never Married 2 🌠 Married Maryland 21215-0036 White 1 Yes 2 X No Specify. and Mental Hygiene.

is marked other than "natural", If Yes, Give Specify. 3 - Widowed 4 - Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government FBI Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental ပ္ Thomas F. McKeon Catherine Higgins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau 9021 Snowford Court; Montgomery Village, MD 10886 Beth Casciano Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 11/3/2009 4 Donation 5 Other (Specify) Atlantic Crematory Glen Burnie, MD Signature of Funeral Service Light ee 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville 10153 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) SCHEMIC Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to or as a consumence of ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Certificate: To Be Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia, mixed type 2 ☐ No 3 🙀 Probably 4 ☐ Unknown 1 Yes Newvoordocrine Concer 24b. Were autopsy findings available 24a. Was an Hospital or Attending Physician: The law 24 hours after death. autopsy performed? Yes 2 12 No prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 8 \(\text{Other (Specify) (VX) S \(\text{OLL} \) } \) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c, Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State Registrar

(Check

only one) 29b. Signature and title of certifier

NOW

31. Date filed (Month, Day, Year)

NOV U J EUUS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANES

MO

32. Registrar's Signature

670

2009

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

N. Charles ST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician NOSOFF Month Dav Year STEPHEN 7:55 PM 8005 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore city Hopkins Hospita L Johns 8. Date of Birth (Month, Day, Year NOV • 29, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 AM 2□ F Hours Year) Country) New Months Days 1957 York Director 133-42-1155 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County York ral", or items 23a or 28a-f shov Examirer must be notified at PA Springettsbury Director 1 □Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 17402 191 South Royal Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. White 1 ∐Yes 2⊠No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Television Producer years 18. Mother's Name *(First, Middle, Maiden Surname)* Reba Kasten 17. Father's Name (First, Middle, Last) Be Norman Nosoff ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 191 South Royal Street York, PA 17402 19a. Informant's Name/Relationship (Type. Print) Joanne F. Nosoff permit. Pages 1 and. Department of Health Important: If Item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cremation Direct 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 11/3/2009 York, PA 4 ☐ Donation 5 ☐ Other (Specify) Crematory Service 22. Name and Address of FacilitChatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD 21215 21. Signature of Funeral Service Licenses lessy arris 23. Par I. Enter the /sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or hear / ailure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Bacterial Pneumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner In I Wenza A

Due to ras a conse wence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 XYes 2 □No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 💢 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🛱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Balmanoullian Res - 000 30,2009 October 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmore mp Ani Balmanoukian 600 N. Wolfe 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

21215-0036

Baltimore, Maryland

P.0.

Division of Vital Records,

			1 - State of Mary Registrar		artment of Health rtificate of Deat		ental Hygi Re	ene g. No 2009	35251
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Robert	L.	Nedrow		2. Date of Death Month October	Day Year 31, 2009	3. Time of Death
~ /	Examin		.4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location			4c. County of Dea	
1			1934 Ho1born Road 5. Social Security Number 6. Sex 7. Age (In	n yrs. last birthday)	Dundall		9 Date of Pirth	Baltim	
	Funeral Director		213-24-6462 XXM 2 F 81	Yrs.	Months Days Hours	rs Min.	8. Date of Birth (Month, Day, Feb. 29		thplace (State or Foreign ountry) ryland
	and w		Usual Residence of Decedent	c. City, Town or Lo	ocation				10d. Inside City Limits
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	ath wi		1934 Holborn Road		21222			United St	ates
386	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, Its Modical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Hispanic of If Yes, specify Cuban, Mexical 1 ☐ Yes 2 ☑ No Specify No Sp		cify Yes or No- lican, etc.)	14. Race - Ame Black, White Specify:	
1215-0036	72 hou natura ilical E	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation		11	6b. Kind of Business	
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2	be filed votal Hygie	Be Co	11 Years 17. Father's Name (First, Middle, Last)	St	eelworker	other's Name	(First, Middle, Ma	Steel I	ndustry
/lan	\$ \$ \$ \$ \$	To B	Charles P. Nedrow			Hati	tie Glov	er	
	~ = > =		19a. Informant's Name/Relationship (Type. Print) Mrs. Amy E. Nedrow (Wife)		ng Address <i>(Street and Nun</i> 4 Holborn Roa				, ,
saitimore,				Ob. Place of Dispo	osition (Name of matory or other place)	Da	ite 20	Oc. Location - City or	Town, State
Ě	t. Pag tment tant: It jury o			-	11 Mem. Gdns	11/4,	/2009	Middle Ri	ver, Marylan
g	permit. Pages : Department of I Important: If ite any Injury or of		21. Sign were of Funeral Service Licensee	79	2. Name and Address of Fac uda-Ruck Fune 922 Wise Ave.	Dund	lalk, Ma	ryland 21	
	Physician /Medical Examiner		23a. Paria. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a condition)	emia	ter the mode of dying, such	as cardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death
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	ecutec and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last	15 (ape 3.				
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ב	The lay te has age 2	dwo					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
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5	Physic this co	၉	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient	2 ER/Outpatien		Nursing Home	e 5 Residen	ce 6 ☐ Other (Spe	ecify)
5	ding later. After funer	io	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day, Yea	ar) 28b. Time of Injury	f 28c. Injury at Work? M 1 □Yes 2[_ 1	d. Describe how	injury occurred	
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ָׁנ	fospital of thours a connected to the filled i	edical Ce	29a. Certifler (Check only construction of the best of my 2 Medical Examiner: On the basis of examiner.)	/ knowledge, death	h occurred at the time, date	and place, ar	nd due to the cau	use(s) and manner a	s stated.
	the thin 24 the Formplet	Med	and manner stated. 29b. Signature and title of certifier		29c. License number				
)	F ≥ F ŏ		Matal NV		D564	66	290	d. Date signed (Mont	09
			30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print)	Timon	10 D	altimor	
	Stat	e	31. Date filed (Month, Day, Year) 32 Registrar's S	Gignature	radu	IVAIL	ue Do	yinmor	e 21222

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State of Maryland / Department of Health and Mental Hygiene and Copies Are Legible.

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Г	Physici	an	Decedent's Name (First, Middle, Last)	1				2. Date of De Month	Da		3. Time of Death
- delay	/Medic		Michael K. Nikole 4a. Facility Name (If not institution, give street a			4b. City, Town, or	Location of Death		31,	2009 c. County of Deat	11:25 PM
	LXaiiiii	iei	313 Hornel Street			Balti				,	
	Funeral Director		5. Social Security Number 6. Sex 1 X M 2 Usual Residence of Decedent	7. Age (In yrs. last t	birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da			hplace (State or Foreign untry) Greece
	yland Jow		10a. State 10b. County	10c. City, To	wn or Loc	ation					10d. Inside City Limits
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	ath with th 23a or 20 ust be no	Funeral Director	10e. Street and Number 313 Hornel Street			10f. Zip Code 21224			US	itizen of What Co	untry?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Modical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 1 ☐ If Y	is Decedent Ever in U.S. ned Forces?]Yes 2 No es, Give ar or Dates:		/as Decedent of H Yes, specify Cuba □Yes 2 1 No	ispanic Origin? (Span, Mexican, Puerto Specify:	oecify Yes or No o Rican, etc.))-	14. Race - Ame Black, White Specify: Wh	e, etc.
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<u>ylaı</u>	should be and Mental s marked o umatic ev	70 E	Kiriakos Nikoleto	s			Sophia	a Konta	akis	3	
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<u>.</u>	s 1 and f Health item 27 other ti		20a. Method of Disposition			HOTHEL ition (Name of atory or other place	Street,	Date Date		ocation - City or	
Baltimore,	t. Pages then tof I tant: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	of from State Oak	Lawn	Cemete	ery 11-4			ltimore	
Bal	permi Depar Impor any ir		21. Signature of Funeral Service Licensee				^{ss of Facility} Bra Low Spri				eral Home
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0	Hos 24 h Fun stely	Medical	(Check only 2 ☐ Medical Examiner: O	To the best of my knowled on the basis of examination and manner stated.	lge, death and/or inv	occurred at the tir estigation, in my o	me, date and place pinion, death occu	, and due to the rred at the time,	cause(date ar	s) and manner as nd place, and due	s stated. to the cause(s)
	To the within 7 To the comple	M	29b. Signature and title of certifier	re		29c. Licenso				ate signed (Monti	
			30. Name and address of person who complete	d cause of death (Item 23a	i) (Type, P	H Bro	ADWAY	BAUT	114	ORE.	09. UD 21231
ı	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	bank	1	-	'	, _		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 26 per doc 887 11-3-09 yt.
State of Maryland Department of Health and Mental Hygiene Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month. 19ay 2009 10:40 am Brown A. Omeze Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Laurel Howard 9311 Madison Ave. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Nigeria 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 🖾 M 2 🗆 F Months Days Hours Sept. 4, 1928 602-40-0076 Yrs. Director 81 Usual Residence of Decedent 28a-f shov 10b. County death with the Maryland 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Columbia MD Howard 1 Tes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6023 Turnabout Lane 21044 Liberia 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 should be filed within 72 hours accept and Mental Hygiene.
n 27 is marked other than "natural", or þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3¥⊠Widowed 4 □ Divorced Specify: Black Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automobile Mechanic Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ျ Afuajuba Unknown Nvema Omeze 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important; If item 27 is any injury or other trau 9311 Madison Ave., Laurel, MD 20723 Ego T. Suah/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Brewerville, Monrovia, 1 K Burial 2 Cremation 3 Removal from State Brewerville Cem. 4 ☐ Donation 5 ☐ Other (Specify) Liberia Nov.16 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. Ken. 313 Talbott Ave., Laurel, MD 20707 M01053 23a. 🎉 rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate

Cause (Disease or iinjury Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial physician s the burial Physician/Medical Box 68760 / the attending p as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year detached P.0. signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? certificate Yes 2 N Division of Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? daughter's 2 No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 C Other (Specify) this residence within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29d. Date signed (Month. Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per Phy G89/1 1/03/09 JH
Amend Item State of Mary 2006, 6870472016 the alth and Mental Hygiene 1 - For State Registrar 35254 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October als 46 AM ohn 2009 /Medical 4a. Facility Name (If not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Glen Burnie Nashington Medical Center Aune If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | 12/16/1933 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Marylan d 212 30 0652 75 Vrs Director Usual Residence of Decedent Show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Exeminer must be notified at Director 1 ☐ Yes 2 ☐ No Glen Burnie 28a-f Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò filed within 72 hours after death with 21060 U.S.A. 26 Elm Dr. or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∆ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give 1954-56 Year or Dates: 1954-56 þ 1 ☐ Yes 2 ☐ No Specify. Specify.White 3 X Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than " Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Parts Manager Automotive 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Madison Oals Nettie Baker 9 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1366 Old Peachtree Rd, Green Bay, VA permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Cindy Meade (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Westchester, 10/27/09 R.A. Ferris & Co. 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature oner As your for nsee Pennsylvania 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 333 S. Parke St, Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sen disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner neumonia Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Jue to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perforn certificate 1 □ Yes 1 ☐ Yes 2 🗆 No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 29b. Signature and title of certifier 29c. License number D68240 Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burnie, MD 2106 Mospita 31. Date filed (Month, Day, 32 Registrar's Signature Year. State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35255 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2009 Margaret Elizabeth Pruitt 6:00 P M October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Month, Day, Year 19/1923 Days Hours Min 1 M 2 V F Director 188-18-9857 86 Yrs Texas Usual Residence of Decedent show 10a. State 10b. County er than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits MDBaltimore 1 X Yes 2 No 這 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6451 N. Charles Street 21212 U.S.A. 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry Je filed wn... ⁴al Hygiene. `≈r than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th Magazine Editor Publishing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Pettigrew Frederick Mellot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 25 Upper Hook Road, Rhinebeck, NY, 12572 John Pruitt/ Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/3/2009 Anatany Gifts Registry Hanover, Maryland 4 🕅 Donation 5 🗌 Other (Specify) 21. Signature of Juneral Service Licence 22. Name and Address of Facility Anatomy Gifts Registry >0/5 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) demento Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of,: cause (Disease or linjury that initiated events physician and the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
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 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Dav Year signed by the a Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ paroxysmal ortial fibrillation, Chronic dostructive Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an monary has performed? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital Other: မ 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Scertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifie 29c. License number R145356

Registrar
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene?

				epartment of Health and Neartificate of Death			35256
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	2. Date of Death	j. No.	3. Time of Death
	Physicia		Alecia M. Powell		Month	Day Year 2009	5:45 p ^M
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			Gilchrist Hospice Center	Towson		Baltimor	e
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birthr	lace (State or Foreign
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aĦi	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee Dorota Marshall	3			vices
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ř	sician: The lar certificate ha irector, page 2		25. Was case referred to medical	00 Plans (Parth (Ohr)	1 🗌 Yes 2	No 1 ☐ Yes	2 🗆 No
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			30. Name abd address of person who completed cause of death (Item 23a) (Typ. ARUN J WANES M 670) N C		an mo		
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		State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 2009 352	57
		1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of D	
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on (ling F After funera	ion:	27. Manner of Death 28a. Date of Injury 28b. Time of Work? 1 New Stigation 28c. Injury at Work? 1 Yes 2 No	
isic office of the cror: / the /	icat	2 Accident	oe <i>r</i> .
Division or Vital Records, to Attending Physician: The law requires tafer death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number or Burlal Route Number or Rural Route Numb	o,
spita nours neral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
Division or Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending scompletely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
To th within To th Comp	Ž	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
		Whe Attouring Whysician D53642 Oct. 2920	9
2		30. Name and address of person who completed cause of coath (Item 23a) (Type, Print) Dr 1/A Rockwille 40208	(7)
		31. Date filed (Month, Day, Year) 32. Registrar's Signature	30
St Regist	ate rar	NOV 0 2 2000	

			1 - State of Maryland / Dep State of Maryland / Dep Registrar Ce	artment of Health and Natificate of Death	nental Hygiei Reg.	ne 2009 35258
	Physicia		Decedent's Name (First, Middle, Last) Jennie Adele Parks		2. Date of Death	RDav21, 24429 3. Time of Death 22: 25A
· 4.	Medic Examir		4a. Facility Name of not institution, give street and number Center	4b. City, Town, or Location of Death	on	4c. Countygo 是ent im ore
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 14 7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea SEPT 17,1	9. Birthplace (State or Foreign Country) Maryland
	laryland 8a-f show ified at	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo Maryland Baltimore County Timoni			10d. Inside City Limits 1 ☐ Yes 2 译No
	ith the N 3a or 28 t be not	Funeral Director	10e. Street and Number 403 Fox Chapel Drive	10f. Zip Code 21093		Citizen of What Country?
(0	er death w or items a		11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto		11. Race - American Indian, Black, White, etc.
-003	hours afte natural", lical Exan	Completed by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates. 15. Decedent's Education 16a, Dece	1 ☐ Yes 2 🖺 No Specify:	166	Specify: White
Maryland 21215-0036	within 72 /giene. ner than "i		Elementary/Seconday (0-12) College (1-4 or 5+) life. D	kind of work done during most of work O NOT use retired) OUSE Keeper	ng	St.Bridgett Church
land	d be filed Jental Hy srked ott	To Be	17. Father's Name (First, Middle, Last) Dioaige Marrocco		e (First, Middle, Maid na Guarigl	,
Man	and 2 should be fill Health and Mental tem 27 is marked of ther traumatic eve			ng Address (Street and Number or Rura Fox Chapel Drive		y or Town, State, Zip Code) .uii, Maryland 21093
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: I fitem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition cemetery, cree		Date 200	c. Location - City or Town, State
Balti	permit. P Departm Importa any injur once.		21. Signature of Funeral Service Licensee	Name and Address of Facility		Parkville, Maryland al&Cremation Ctr.,P.A. Maryland 21093
- 0	nysician/		23a. Part I. Inter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final ADRTIC ANEURYS			Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):			
3	nsit	Examiner	Sequentially list conditions, if any harmonic forms a consequence of cause. Enter Underlying Cause (Disease or imjury			
0	cer illicate be executed adding physician and use as the burial-transit	dical Exa	that initiated events resulting in death) Last Due to (or as a consequence of):			
68760	ing phys		IF FEMALE:			
Š S	e atte	Physician/M	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ls, P.O.	requires that the de been signed by the s should be detached	ed by PI	Part II. Other significant conditions contributing to death but not resulting in the CORONARY ARTERY DISEASE	inderlying cause given in Part I.		co use contribute to the cause of death? 2 Lance
Division of Vital Records,	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Completed by	HYPERTENSION		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No
/ital	s certificate has t		25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (Check	only one)	
on of \	ath. : After this e funeral c		27. Manner of Death 1 In Natural 5 □ Pending 2 □ Accident Investigation 2 □ Accident Investigation		me 5 Li Residence 28d. Describe how in	e 6 Other (Specify) njury occurred
Jivisic	s after des	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
- Figure 1	in 24 hour he Funera	Medical	29a. Certifler 1 Certifying Physician: To the best of my knowledge, death (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	tigation, in my opinion, death occurred at	the time, date and pla	ace, and due to the cause(s) and manner stated.
اً ا	with Com		29b. Signature and title of certifier	29c. License number D37254	29d.	Date signed (Month, Day, Year)
	21		30. Name and address of person who completed cause of death (Item 23a) (Type, FBOON FOH LIM, M.D. 76Ø1 OSLER		MARYLAND	21204
H	Stat Registra		31. Date filed (Month, Day, Year) NOV 0 3 2009 32. Refisitate Signature	have		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10/22/2009 Pipkin George 10:41 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 ₹ M 2 □ F 1 2 P25 7 Year) 247-46-2917 81 McColl Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 √2 Yes 2 □ No DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 5901 8th St. 20011 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 2 X No 1 ☐ Yes 2 😾 No Specify: 3 Widowed 4 □ Divorced Specify: Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Porter Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Luther Pipkin Paige 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Essex/Sister 8th St. N.E. Washington, DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place)

Md National Cemetery 11/2/2009 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Johnson&Jenkins Funeral Home 21. Signature of Fune & Sec. 716 Kennedy St. N.W. Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi physician Physician/Medical ISCHEMIA P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ate has been signed by the atte page 2 should be detached for i Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown LICER DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe NEUROPATHY certificate 1 ☐ Yes 2 ☐ No Yes 2 **Division of Vital** To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

Registrar

31. Date fled (Month, Day, Year

person who completed cause of death (Item 23a) (Type, Print)

701 Kando

32. Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

ZIG. ROCKVILLY MD. ZOSSZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** P^{M} James Edward Palmer 6:24 31 2009 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months **X**M 2□ F Davs Hours Director 214-26-5061 Nov. 8, 1930 Maryland 78 Usual Residence of Decedent after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examination to nother traumatic event. Yes 2 No Directo Maryland | Harford Bel Air 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 601 East MacPhail Road 21014 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. tyTyYes 2 □ No 1 Never Married 2 Married Maryland 21215-0036 1 □Yes ŽVNo Specify þ Specify: 3√Widowed 4 □ Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner & Operator Dentist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mathias (nmn) Palmer Marian Frances Larce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher J. Palmer / Son 200 Yardley Court, Abingdon, Maryland 21009 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 11-4-09 Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 Lauch 23a. Part 1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** hronic Obstructive TUIMMAN JOKNOWY disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner MKnow Coronary Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Pleura ELTUSIO Due to (or as a consequence of) physician 68760 Physician/Medical Pneumotherax the attending Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) □Yes 2□No o 9 Unknown 9 Unknown signed by O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? this certificate has be all director, page 2 s 24a. Was an 1 ☐ Yes 2 ♣No 1 ☐Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ➡Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑No ၉ Director: After that in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0065421 October, 31, 2009 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chesapeake Drive, Bel Air, Maryland 21014 K. FisHerMO 500 UPPER Christa 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 29, 200 **Physician** 307 VERMELL POWELL-HAWKINS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner etimore N/A reneral 8. Date of Birth (Month, Day, Year) 2-22-1942 9. Birthplace (State or Foreign Country)
SOUTH CAROLINA If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛣 F 67 217-40-3604 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show Department of Health and Mental Hygiene important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 29a or 28a-f show important: If it is wedical Examinar must be notified at once. 1 XYes 2 No Director MD. N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 931 BROOKS LANE 1st FLOOR 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ∭Mo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No BLACK 2 Specify: 3℃Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **HEALTHCARE** -12--0-NURSE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN Be THELMA WILLIAMS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3603 SPAULDING AVE. BALTIMORE, MARYLAND 21215 MICHELE POWELL (DAUGHTER) 20c. Location - City or Town, State Date Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐ Removal from State MT. ZION CEMETERY 11-6-2009 BALTIMORE, MARYLAND 5 ☐ Other (Specify) 4 Donation HIBNER2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Cause (Final or condition in death) **Physician** ear /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a co attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 □Yes 2 □No ed by the a 9 Unknown 9 ☐ Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 17 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 112 Yes 2 □ No 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide

Hospital or Attending Physician: The law requires that the death certificate be execute thours after death.

Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Pages 1

6 ☐ Could not be

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of frtifier 29c. License number 11-2-2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHIANG

State Registrar

Medical

31. Date filed (Month, Day, 32. Registrar's Signature

within 2. the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2:50 A M **Physician** GEORGE E. POLK October,28 2009 /Medical 4a. Facilify Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner of Baltimore Balto. City N/A Hospital 5. Social Security Number If Under 1 Year Date of Birth Month, Day, Year) 8–25–1942 9. Birthplace (State or Foreign Funeral Min. Days Hours VIRGINIA 225-54-0676 67 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 1 XYes 2 □ No Funeral Director N/A MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 2210 LUKEWOOD DR. 21207 USA . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married BLACK 1 ☐ Yes 2XNo Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SANDBLASTER COAST GUARD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN Be BOOKER T. POLK ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MARGARITA POLK (WIFE) 2210 LUKEWOOD DR. BALTIMORE, MARYLAND 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation ☐Removal from State 10-31-2009 BALTIMORE, MARYLAND 4 Donation 5 ☐ Other (Specify) HIBNER 2. Name and Address of Facility REDD FUNERAL SERVICE 21. Signature of F vice Ligense JONAVHAX 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Partl. E fer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, if heart failure. List only one cause on each line. Immediately duse (Final disease or condition resulting in death) a. Acute Renal Tailure. Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician 3 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Urinary Tray Due to (or as a consequence of): Tract Infection attending physician and Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☑ Unknown 2 ☐ No 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an cate has l autopsy perform 2 2 Be 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To within 24 hours af er death. To the Funeral Director: A er this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident i by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

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mpleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Caliatan

31. Date filed (Month, Day, Year)

NOV U 3 ZUU9

October 28, 2009

2901 West Belvedere Baltimore MD 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 35263 Certificate of Death 2, Date of Death 1. Decedent's Name (First, Middle, Last) 5:21a [™] October 28, 2009 Leanna Mae Packard 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harford Memorial Hospital Havre de Grace Harford Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 1, 1921 7. Age (In yrs. last birthday) 5. Social Security Number 1 M 2 F 88 Virginia 215-34-1879 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1≰Yes 2□No Harford Maryland Aberdeen 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Walker Street 21001 USA 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: white 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) laborer 0 manufactoring 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John E. Rudd Jessie E. Radcliff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pritt Lane, BelAir, MD 21014 <u> Carol S. Akers (daughter)</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BelAir Memorial Gardens 11/3/09 | Bel Air, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, P.A. Tarring-Cargo Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown

Physician /Medical Examiner

attending physician and for use as the burial-tran

stor; After this certificate has been signed by the the funeral director, page 2 should be detached

after death Director:

24 hours after de le Funeral Directo bletely filled in by the

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Be Completed

Hospital or Attending Physician: The law requires that the death certificate be execute

Division of Vital Records, P.O. Box 68760,

Kard, Leanna

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

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Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evantment with the notified at once.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

3 Ectopic pregnancy 5 Other (specify)	
0_0 (4,00))	

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobac	co use con	tribute to the cau	ise of death?
1 ☐ Yes	2 □ No	3 ☐ Probably	4. Unknown

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25. Was case referred to medical examiner?		26. Place of Death
examiner:	Linonital: 4	Othor

23e. Did tobacco di	36 6011	inbute to t	110 040	ou or would
1 ☐ Yes 2 ☐] No	3 ☐ Prol	bably	4.☐ Unknown
24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	l	Were auto prior to co death? 1 ☐ Yes	. ,	ndings available on of cause of No

				26. Place of Dea	th (Check only one)	
ospital:	1 Inpatient 2	ER/Outpatient	3 ☐ DOA	Other: 4 Nursing H	ome 5 Residence	6 ☐ Other (Specify)
28a.	Date of Injury (Month, Day, Year	28b. Time of Injury	28c.	Injury at Work?	28d. Describe how inj	ury occurred

1 Yes 2	io	Hospital: 1 Inpatient 2	☐ ER/Outpatient	3 ☐ DOA	Other:	4 ☐ Nursing H	ome 5 Residence	6 ☐ Other
27. Manner of Death 1 Natural 2 Accident	5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of		Injury at Work?	2	28d. Describe how in	jury occurred
3 ☐ Suicide	6 ☐ Could not be	B Dinne of Injury At	home form street	t factory of	Hice		28f Location (Street	and Number

2 Accident	investigation	M	1 ∐Yes 2 ∐No	
3 ☐ Suicide 4 ☐ Homicide	6 ☐Could not be determined	28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	ory, office	28f. Location (Street and Number or Rural Route Number City or Town, State)

0	1 Yes 2 No		10Spital: 1	☑Inpatient 2 🗆] ER/Outpatient	3 🔲	DOA Mursing F	lome 5□ P	tesidence	6 ☐ Other (Specify)	
dical Certification: T	27. Manner of Death 1 ☑ Natural 5 ☐ 2 ☐ Accident	Pending investigation		ate of Injury Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Descri	be how inji	ury occurred	
	3 ☐ Suicide 6 6 4 ☐ Homicide	Could not be determined	28e. Pl	lace of Injury - At huilding, etc. (Spec	nome, farm, street	, fact	ory, office	28f. Locatio City or	n (Street a Town, Sta	and Number or Rural Rou te)	te Numb
	29a. Certifier (Check only 2 one)	Certifying Phy Medical Exami	ner: On the	the best of my kn he basis of examin nanner stated.	owledge, death o ation and/or inve	ccurr	ed at the time, date and plaction, in my opinion, death occi	e, and due to urred at the ti	the cause me, date a	(s) and manner as stated. nd place, and due to the o	:ause(s)
Me	29h Signature and title	of certifier	1	,		2	29c. License number		29d. D	ate signed (Month, Day,	Year)

(Check only one)	2☐ Medical Examin	er: On the basis of exam and manner stated.	nination and/or investigation, in my opinion, death occurred at the time	e, date and place, and due to the caus
29b. Signature and	d title of certifier	1-1	29c. License number	29d. Date signed (Month, Day, Year,

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State Registrar 31. Date filed (Month, Day, Year)

			for State Registrar	State	of Marylan		irtment of H			giene 0)9	35264
	~o		Decedent's Name (First, Middle	a, Last)					2. Date of De	ath		3. Time of Death
	Physici /Medio		Twila Eli	zabeth Qu	esenber	ry			OCT che	r. 28	Year 2009	2: 05 PM
	Examin		4a. Facility Name (If not institution	, give street and n	umber)		4b. City, Town, or	Location of Death		4c. County	of Death	
			Manor Care Nur	sing Cent	er		Towson			Ba1	timo	re
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birthp	lace (State or Foreign
ш	Director		232-26-8722	1 □ M 2 💢 F		92 Yrs.			Aug. 7			Virginia
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	f sho	ō	MD B	altimore	-	Towson						1 ☐ Yes 2 🛣 No
	28a	Olrector	10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Cour	ntry?
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	ms 2	Funeral	11. Marital Status	12. Was De	cedent Ever in U.	.S. 13. V	Vas Decedent of Hi Yes, specify Cubar		ecify Yes or No		e - Americ	
9	hin 72 hours after death with the Maryland 9. In Insturel', or tems 23s or 28s-1 show Medical Examinar must be invilled at		1 Never Married 2 Marr	ied 1 X Yes	orces? 2 □ No	li			Rican, etc.)		ck, White,	
21215-0036	ral', c	d by	3 X Widowed 4 ☐ Divorced	Year or	2 □ No live Dates: 44 • - 4	15'	☐ Yes 2M No	Specify:		Specify	v:Whit	e
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	abe funtal h	Be C	Friend Cox Lo		. 10				Jiolet	Toothma	•	
Maryland	should be nd Mental marked o	은	19a. Informant's Name/Relations		: L	19h Mailin	g Address (Street a					Code)
<u>8</u>	ith ar 27 ts r trau		Jeff Snodgrass				Manor R				otato, Ep	0000)
ā,	s 1 ar f Hea item other		20a. Method of Disposition		20b. P	lace of Dispos	sition /Name of	ı	Date	20c. Location -	City or To	wn, State
Ë	Page: ent o nt: If ry or		1 X Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (S)		^{n State} Ba.	ltimore Cemete	natory or other place Nationa	$\stackrel{\text{Nov.}}{1}$	-	Balti	more	. MD
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If Item 27 is marked any injury or other traumatic a <u>ODCe</u> .		21. Signature of Funeral Septice				Name and Addres Smmon Fun					
n	Par in Se		1	Michael	J. Flag	gle 1	W. Pado:	erai nome nia koad	Timon	ium, MD	2109.	inc.
	100		23a. P mt1. Enter the absect r shock, or heart failure. List	complications that	caused the death		or the mode of dying	, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	K	tente	3	stood	los:				Onset and Death
	/Medical		resulting in death)	a. Due to	(or as a consequ				No.			1 000
	Examiner		Sequentially list conditions.	b. Go	stroiv	ntes-	tinal	Blee	ding			
4	P :	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a consequ	uence of):						
12	and I-tran	Examiner	that initiated events resulting in death) Last	C	(or as a consequ	uanco of):			-			
8/60,	cate be executed physician and the burial-transit	al E		00010	(or as a consequ	dence or).						
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×	that the death certified by the attending I	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome of pregna	ncy				23d Dat	te of delive	in.
X P P	atter of for u	clar	in the past 12 months?	1 Live	birth 2 Fetal	Ideath 3 🗌	Ectopic pregnancy Other (specify)			Mo		Day Year
j.	the c y the achec	Physician/M	9 Unknown	9□ Unki			(7-1-7)					
, T	law requires that the as been signed by the 2 should be detache	by P	Part II. Other significant condition	ns contributing to	death but not resu	ulting in the un	derlying cause give	n in Part I.	23e. Did t	obacco use conti	ribute to th	e cause of death?
ğ	quire an sig uld b		Demen	ha					10	Yes 2 No	3 🗌 Prob	ably 4 □Unknown
Hecords	aw re	ompleted	Conses	five	Hean	1- f	ai bur	P	24a. Was	an 24b. \	Vere auto	psy findings available
ř	sician: The law s certificate has b lirector, page 2 s		0			4			autoj perfo 1 ☐ Yes	rmed?	death?	npletion of cause of 2 No
VITAI	ian: artifica ctor. I	Be C	25. Was case referred to medical examiner?					26. Place of Deat				
0 0	Physician: this certific ral director.	10	1 ☐ Yes 2 ☐ No	Hospital: 1	Inpatient 2	ER/Outpatient	3□ DOA Othe	4 Nursing Ho	me 5 🗆 Resi	dence 6 Oth	er (Specity)
	fter free	on:	27. Manner of Death 1 Natural 5 ☐ Pendin	28a. Date (Mo	of Injury oth, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe	now injury occurr	ed	
VISION	Attanding r death. sctor: After by the fune	catl	2 Accident investig 3 Suicide 6 Could r	ation				'es 2□No				
$\frac{1}{2}$	or At after of Dirac in by	Certification;	4 Homicide determ	ned 288. Plac	e of Injury - At ho ting, etc. (Specify	ome, farm, stre /)	et, factory, office		28f. Location (City or To	Street and Numb vn, State)	er or Rura	I Route Number,
_	pital ours a aral l		29a, Certifier 1 X Certifyin	g Physician: To th	a heat of my know	ulodao dooth		a data and alam				
	24 hc 24 hc Fun etely	edical	(Check only one)	Examiner: On the	basis of examinat	tion and/or inv	occurred at the tim estigation, in my op	e, date and place, inion, death occur	and due to the ed at the time,	cause(s) and ma date and place, a	nner as stand due to	ated. the cause(s)
	To the Hospital or Attandi within 24 hours after death, To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier				29c. License			29d. Date signed		
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١	X		30. Name and address of person	no completed cau	ise of death (Item	eca) (Type, F	Doc	1		00(00	1	
	ψ`		Richard Ac	eldo M	. D. 8	415	Bellon	9 Leme	42	16, TO	WSU	n, MO 2/20
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end item 9 per fh g897 11-3-09 yt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** KUSS 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Picks Cille nursing 1 home 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2014 F Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Picksville imore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SydBrooks Lyne Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes (2DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on the filed within 72 hours after one of Health and Mental Hygiene. Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes ②No Specify: 3 □ Widowed 4 □ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) UNV UNK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ N 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Prayer WSON MP. MYS 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 209 21. Signature of Funeral Service 22. Name and Address of Facility Licensee Yarda FH 23a. Part1. Enter the disease shock, or heart failure or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** BREA Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. East Uncorpung Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760. signed by the attending physician d be detached for use as the buriz Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2. No 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the f 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. BUCRNP the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ago, somo

Registrar

State 31. Date filed (Month, Day, Year) NOV 0 3 2009



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 35266 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 1, 2009 Irene Rodgers 1:30 \mathbf{p}^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5 Social Security Number g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🏲 F Min. Days Hours May May Year 7 278-22-4743 82 Yrs Pennsylvania Director Usual Residence of Decedent nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland attrinent of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injuy or other traumatic event, the Medical Examiner must be notified at injuy or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5204 Hillwell Road 21229 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married White 1 ☐ Yes 2 K No Specify: Specify: 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Printer Printing Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 1gb. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
342 Westshire Road Baltimore, Maryland 21229 19a. Informant's Name/Relationship (Type, Print) David W. Crosby 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory 20a. Method of Disposition November 2, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Signature of Funeral Service Licensee Gremation Society of Maryland, Inc. 299 Frederick Road_Baltimore, Maryland 21228 Alice Iser 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Cardiony a path Du to (or as a consequence of): Medical resulting in death) **Examiner** Se yuentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last physician Completed by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Day Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 No Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Yes 2 A Director: After this certificate 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 D Other (Specify) WOSPILL Certificate: To 2 📜 No 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident 1 Yes 2 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner 1. the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the date (s) and manner stated (Check

State

Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital or Attending Physician: The law requires that the death certificate be

of Vital Records,

Division

Box 68760

Maryland 21215-0036

Baltimore,

00

9

29c. License number

Churus

ZA

29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 2009 35267 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ F. Mont 10 30 Day Rogers Dorothy 2009 6:50a. M Medical 4a. Facility Name (if not institution, give street and number ng Cranberry Cottage Assittant Examiner 4b. City, Town, or Location of Death 4c. County of Death Balto Burni 5. Social Security Number 8. Date of Birth (Month, Day, Year) 10-24-1917 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 - M 2 XF Hours Director 92 579-07**-**0294 IL Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Balto Glen Burnie 1 ☐ Yes 2X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1102 McHenry Drive 21061 S Α Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 2 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No 3 Midowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical 12th grade N/A Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Oscar Fosdick Lottie Corbett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Petryszak-Niece 1102 McHenry Drive Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 🛱 Burial 2 🗆 Cremation 3 🗆 Removal from State Garden of Memories11-2-2009 4 ☐ Donation 5 ☐ Other (Specify) Washington, N.J. 21. Signature of Funeral Service Licensee March Fune IIOI East North Ave, Baltimore, Md 21202 Glade W) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Priysician on 425to lurg disease or condition resulting in death) y par Medical Due to (out s a consequence of) Examiner Sequentially list conditions, if any hading to immedicause. Enter Underlying Cause (Disease or iinjury Tue to for as a consequence of signed by the attending physician and a be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Day 2 1 No Yes 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performed? After this certificate he funeral director, page 2 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending М 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death To the Funeral Director: completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗠 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 100 30 V 30. Name and address of se of death (Item 23a) (Type, Print person wbo-completed ca A 49.2 UF Vul 100 31. Date filed (Month, Day, State 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day T Month Year **Physician** okound tree 00 /Medical Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner more 4Ture Care 91 NO If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 2-14-1926 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 💢 F 220-22-6280 N.C. Director 83 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show d other than "natural", or items 23a or 28a-f show event, the Medical Experience resides at 1 Yes 2 □ No Director n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 804 Wicklow Road 21229 U S Α Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status 1 Never Married 2 Married 1 □Yes 2X No Black Specify: 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any injury or other traumatic event." Elementary/Secondary (0-12) College (1-4or 5+) Johns Hopkins 12th grade Cook Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Green မ Effie Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Deborah Hemphill-daughter 2776 Kinsey Avenue Balto, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Western Star 11-7-2009 Catonsville, MD 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee 1+1 Mo1363 1101 E. North Avenue MD 21202 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** (1 E310 700 K16 disease or condition resulting in death) /Medical Due to (or as a consuluence of): Examiner solece Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and the burial-transit OSOMERY 91 Due to (or as a consequence of): Physician/Medical attending p use as IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached for 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 : autopsy performed? 1 ☐ Yes 2 ☐ No ∣□Yes 2**V** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Tes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 ☐ Pending investigation within 24 hours arter occ...
To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

P.O. I of Vital Records, To the Hospital or Attending Physician: Division

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

501

Pogratrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

			1 - State of Maryland / State of Maryland / Registrar		rtment of Hea tificate of Dea			giene Reg. No. 200	9 (35269
	Physicia	an	1. Decedent's Name (First, Middle, Last)		- 30 0	p .	2. Date of De Month	Day Ye	ar	. Time of Death
~*	/Medic	al	LOUISE ROLLISON 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc		October	4c. County of E		2:50 a ^M
	Examin Funeral Director	er	St. Thomas De More 5. Social Security Number 6. Sex 7. Age (In yrs. last b) 577-52-0889 1 □ M 2 ☑ F 73	oirthday) Yrs.	Hyattsv If Under 1 Year If U	71110	8. Date of Bir (Month, Da December	Prince	Coor	ge's State or Foreign
	פ	,	Usual Residence of Decedent 10a. State	wn or Loc	eation					Inside City Limits
	Maryla -f sho	tor	DC Washin							1 ⊠ Yes 2□No
	h the or 28a	Director	10e. Street and Number	.gcon	10f. Zip Code			10g. Citizen of What	Country?	?
	ath wil	ral [64 U Street, NW		20001			USA		
036	72 hours after death with the Maryland Instural", or items 23a or 28a-f show iteal Evantiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of Hispar Yes, specify Cuban, M □Yes 2 X No <i>Sp</i>	nic Origin? (Spo lexican, Puerto pecify:	ecify Yes or No Rican, etc.)	14. Race - A Black, W Specify:	American I Vhite, etc. Blac	
1215-0036		Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give k life. D	ent's Usual Occupation kind of work done during OO NOT use retired)	n ng most of worki	ng	16b. Kind of Busine		try
2	filed within Hygiene. other than '		11th 17. Father's Name (First, Middle, Last)	Hous	ekeeper	Mother's Name	(First Middle	Privat , Maiden Surname)	e	
anc	be d c	To Be	Richard Jordan			Rebecca		Clenon		
	Pages 1 and 2 should be filed vinent of Health and Mental Hygiciant: If Item 27 is marked other i lury or other traumatic event, It	۲		,	g Address (Street and I				te, Zip Co	ede)
Baltimore,	Pages 1 a nent of He ant: If item ury or othe		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ery, crem	sition (Name of latory or other place) L Cemetery	1) ate	20c. Location - City		
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Tuneral Service Licensee		Name and Address of Kennedy					al Home 20011
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition esulting in death)	o not ente		uch as cardiac	or respiratory a	rrest,	Ap Int	pproximate terval Between nset and Death
	/Medical Examiner	_	Due to (or as a consequence Sequentially list conditions.							
	ecuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c							
58760,	ificate be executed g physician and as the burial-transit	edical E	Due to (or as a consequence) OT):						
O. Box	ath certif attending for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death		Ectopic pregnancy Other (specify)			23d. Date of Month		y Year
ds, P.	law requires that the de as been signed by the 2 should be detached	by	Part II. Other significant conditions contributing to death but not resulting		derlying cause given in	Part I.		tobacco use contribu Yes 2 ☐ No 3 ☐		
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Ita	ician: sertific	Be	25. Was case referred to medical examiner?		26.	. Place of Death				
10	Phys r this ral dir	ا يا	1 Yes 2 No Hospital: 1 Inpatient 2 ER/C 27. Manner of Death 28a. Date of Injury 28b.	Outpatient Time of				dence 6 Other (Specify)	
ion	ending eath. or: Afte he fune	ation	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury	28c. Injury at Work? M 1 □ Yes					
DIVISION	tal or Atters after de al Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, to building, etc. (Specify)	arm, stre	et, factory, office		28f. Location (City or To	Street and Number own, State)	r Rural Ro	oute Number,
	To the Hospital or Attending Physician: The law within 24 hours after defector. After, this certificate has completely filled in by the funeral director, page 2 s	Medical (29a. Certifier (Check only one) 1	and/or inv	estigation, in my opinio	on, death occur	red at the time,	date and place, and	due to the	e cause(s)
	Vorth com	Σ	29b. Signature and title of certifler	0	29c. License nur	mber		29d. Date signed (N	lonth, Day	y, Year)
•			20 Name and address of pages with a small distribution) /Turn	Drint)	279		Uctuber	. 23	2009
-	6V		30. Name and address of person who completed cause of death (Item 23a)	Ju-g-	ensbungi	Ral Hy	attsu	ille MD	28	781
ı	Sta Registra		29b. Signature and title of certifler Compared to the complete cause of death (Item 23a) Compared to the complete cause of death (Item 23a) Compared to the compared to the complete cause of death (Item 23a) Compared to the compar	Cal	•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ridgley Elizabeth Doris 9:25 AM October 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Frederick Villa Nursing Home Catonsville 8. Date of Birth Tan. 24, 1917 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 ☐ M 2 🗓 F 215-07-1066 Maryland 92 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director Baltimore Baltimore 1 Yes 2X No MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 23a Funeral USA 21207 927 St. Agnes Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Was Decedent Ever in U.S. Black, White, etc. 1 ☐ Yes 2 🖾 No If Yes, Give "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. Completed White 3 K Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene.
27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Louisa Von der Wetern Morris Oliver Penn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 927 St. Agnes Lane; Baltimore, MD 21207 William A. Ridgley 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 A Burial 2 Cremation 3 Removal from State 11/2/2009 Woodlawn, MD Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Sery 630 Edmondson Avenue; Catonsville MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final PNEUMONIA Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner FAILURG ENAL Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to for as a consequence of attending physician and for use as the burial-transit MULTIPLE DECUBITI Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DE MENTIA. 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? Yes 2 No death? 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 🗆 Yes 2 🗆 No (Month, Day, Year) 1 Natural 5 Pending injury M Investigation Accident

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific

Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifig License number 29d. Date signed (Month, Day, Year) 30469 13 october PARKWAY \$ 308, COLUMBIN; 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N B VELLA WK 850, COLUMBIA 100 MD 21045. 32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year) NOV 03 2009

Baltimore, Maryland 21215-0036

the death certificate be executed

Division or Vital Records, P.O. Box 68760.

or Attending Physician:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Sinclair Stewart, Jr. 31, 12:28AM October 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Manor Care of Chevy Chase Chevy Chase Montgomery Date of Birth (Month, Day, Year) 7/15/1929 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Birthplace (State or Foreign Country) Days 1 1 M 2 □ F 349-24-7389 80 Louisiana Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 X Yes 2 □ No MD Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8700 Jones Mill Road 20815 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be flied within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite, any injury or other traumatic event, the Medical Ex-miner and. 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Specify: \$ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Government 3 18. Mother's Name (First, Middle, Maiden Surname) Unk 17. Father's Name (First, Middle, Last) Be Sinclair Stewart, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Calhoun/Power of Attorney 2908 Rose Valley Drive, Ft. Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/3/2009 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part1. Enter the disease, recomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical SBS IF FEMALE: use 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1□Yes 2□No 9□Unknown 9 ☐ Unknown s been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Noknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform this certificate No. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director; 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical сопретель (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00054566 00

State Registrar

DHMH 17 Rev 1/2001

, 9801 Crongia Annu # 1-17, silverigong on Drogo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bhogavilli

32. Registrar's Signature

Sunitha

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35272 State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 6:25PM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death County of Death Examiner OWSON If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Months Hours Min 1 M 2 W Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 □ No more 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 212 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give 21215-0036 1 ☐ Yes 2 No Specify: 3 ₩Widowed 4 □ Divorced Specify: lac Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industr Give kind of work done during most of working life. DO NOT use retired (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State emetery, crematery or other place 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a MON-- SWOUL COLL wouth. disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No page 2 should be detached for Month Day Year 1 ☐ Yes ∠ ≠ 2 ☐ Unknown Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 2 🗌 No Yes Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Division of Vital examiner? Hospital Other Certificate: To 6 X Other (Specify) +CFOICO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Signatur 29d. Date signed (Month, Day, Year) Moumber 1,200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sutrala 31. Date filed (Month, Day, Year) 32. Registrar's Sig State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician HOBER Carol Ann Sauer 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Samare 0 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Feb. 5, 1945 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days Min 1 □ M 2 🕱 F 232 72 5130 Director Maryland 64 Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits or 28a-f shov the Medical Examination set by notified at Director Maryland Baltimore Middle River 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 30 Hydroplane Drive USA items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Was Deceden 2. Armed Forces? 1 ∏Yes 2 X No 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2X Married jo, Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: White þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other than any injury or other traumatic event, the Once. Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Philmore May Withrow Ruth Virginia Crookshanks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David George Sauer (Husband) 30 Hydroplane Dr. Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gardens 11/2/2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signaure of Funeral Service ^{22. Name and Address of Facility}
Bruzdzinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, il any, leading to intraction cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) The law requires that the death certificate be executed Examir and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ SIOI 1 Xyes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Division of Vital 2 🗆 No 1 ☐ Yes 2 X No 1 ☐ Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number M.D

State

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Dh Ni Shant 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Andrew Eirhart Strebeck, Jr. \mathbf{P}^{M} 4:26 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3831 Clarks Point Road Middle River Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**XX**M 2 □ F Months Days Hours Min. 0277371925 Mary land 214-20-5190 84 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Middle River 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3831 Clarks Point Road 21220 U.S.A. Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. δ 1 Never Married 2 Married 1XXYes If Yes, Give altimore, Maryland 21215-0036 WWII 1 Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Police Officer Balto. City Police Dep Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Andrew Eirhart Strebeck Alice Ada Gough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Strebeck (Son) 3829 Clarks Point Road, Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of I Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gardens of Faith 11/03/2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} 1407 old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ IABETE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of impury that initiated events Examine Due to (or as a consequence of) burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be as the l IF FEMALE ase 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō in the past 12 months? Day 1 Yes 2 No the detached P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed peen FIBRILLATION. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforn certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifications and the Funeral Director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be the 1 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

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DHMH 17 Rev 7/2009

only one

KISHORE

29b. Signature and title of certifier

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

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9600

Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

NORTH PT. RD.

038635- 5A

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HOLIARD

MO 2105

			for State	State of Maryland / Depa		lental Hygier	ne	05075
		_	Registrar 1. Decedent's Name (First, Middle, Last)	Cei	rtificate of Death	Reg. I	vo. 2009	352/5 3. Time of Death
	Physici		ROBIN L.	Simms		Month [Day Year 2009	12;08pm
-	/Medio Examir		4a. Facility Name (If not institution, give stre	· ·	4b. City, Town, or Location of Death		c. County of Death	
			MENCY MEDICAL CEN 5. Social Security Number 0 6. Sex	7. Age (In yrs. last birthday)	BACTIMORE If Under 1 Year If Under 24 Hrs.]	8. Date of Birth	BALTIMURE O Birthol	ace (State or Foreign
	Funeral Director			2 XF 53 Yrs.	Months Days Hours Min.	(Month, Day, Yea	1956 M	ry)
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	or 28	Director	10e. Street and Number	1 01	10f. Zip Code	10g.	Citizen of What Count	ry?
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212	within 72 ho iene. than "natui hy Mudieni	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	ompleted) (Give	kind of work done during most of working NOT use retired)		Kind of Business/Indi	C - / .
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and	ev ev	To Be	17. Father's Name (First, Middle, Last)	Simms	Ne TT	(First, Middle, Maid	a lo	
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altimore,	Pages nent of I		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	sition (Name of patory or other place)	1	Location - City or Tov	<i>'</i>
<u>=</u>	permit. Pages Department or Important: If i any Injury or once.	3	21. Signatur of Funeral Service Lice	1111110	Name and Address of acility	70 Freds	atons.	KSO TO THE RESIDENCE OF THE PARTY OF THE PAR
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<u>}</u>	all or A safter I Direct d in by	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. <i>(Specify)</i>	set, lactory, office	City or Town, Sta	and Number or Rural ate)	Houte Number,
	on the nospital or Attending Prystician; The law requires that the death certini within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as		Check only Medical Examiner	an: To the best of my knowledge, death On the basis of examination and/or inv	rectination in my aninian death accurr	ad at the time date o	and place, and due to	ated. the cause(s)
-	vithin 2 Fo the comple	Medical	29b. Signature and title of certifier	and manner stated.	29c. License number	29d. [Date signed (Month, D	ay, Year)
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			30. Name and address of person who comp	eted cause of death (Item 23a) (Type, I	Print)	1		
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			State of Maryland / Departmen	t of Health and I e of Death		0000	05076
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	Physici /Medi		William Douglas Sullivan			Day 2009 Year	2:45P M
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ľ	Funeral Director		5. Social Security Number 213-12-0677 6. Sex 7. Age (In yrs. last birthday) If Under Months 4. Man 2 F 86 Yrs.	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day,) Mar • 13	^(ear) 1923 Mar	lace (State or Foreign try) Yland
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	ems er mu	Funeral		dent of Hispanic Origin? (Spirify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White,	
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Baltimore,	permit. Pages ' Department of F Important: If ite any Injury or ot once.		21. Signature of Funeral Service Licensee 22. Name an	d Address of Facility $\mathop{\mathbb{E}} \mathop{\mathbb{C}} brace$	thardt F	uneral Ch	apel P.A.
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Box	ath cer tendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pr	egnancy		23d. Date of delive	,
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	To the within 2 To the complet	Me		. License number	290	. Date signed (Month, I	Day, Year)
			May 2, Waldry In Ml.	017154		10/20/20	09
i			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	H	1 .	1-10-10-	
			Dr. E. Walden JA. 300 ST, Loke Circle 31. Date filed (Month, Day, Year) 2. Registrar's Signature	Westmi	nslef, Mi	d. 21158	
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day 1256 4 **Physician** Chais Subre 31 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maryland General Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year, 10-22-56 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 X M 2 □ F 53 Director 219-66-5502 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time XT is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Evaninar must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits X1X Yes 2 □ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1608 East Preston Street 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian,
Black, White, etc African 11. Marital Status 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: American 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade NA Self-employed Wholesaler 18. Mother's Name (First, Middle, Maiden Surname) unk. 17. Father's Name (First, Middle, Last) Be Scott Benjamin Helen ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monica Sabree Preston Street Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State King Mem. Pk. Cem 11-03-09 Randallstown, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee \$38 N. Gilmor Street Baltimore, MD 21217 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Aspira him PARUmonia disease or condition resulting in death) hour /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown cate has been signed page 2 should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Vital 1 ☐ Yes 2 No 1 ☐ Yes 2 K No or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this ō 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Division 1 Natural 1 ☐Yes 2 ☐No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7 43386 11.2.09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8405 Balkinger Dani-1 Itomand 821 Foko 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV Registrar

			For State	State	of Marylan		artment of I			_	gien Reg. No	711111	35278
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2 should be filed within 72 hours after death with the Maryland	and Is ma		19a. Informant's Name/Relations				-					or Town, State, Zip	
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for use as the burial-transit Box 68760. P.O. Division of Vital Records, After this certificate funeral director, page

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10 30 2009 a M 06:35 Bertie Steigerwald 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 9223 Belair Road Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🔀 F 09 /03/19 17 214-14-2298 92 Tennessee Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-f show any Injury or other traumetic event, If we Marifical Examples in the resistence. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD Baltimor e Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21236 U.S.A. 9223 Belair Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 👿 No Specify Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Riveter Martin's Airport 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mallicoat Harville Hattie ဂ္ဂ Lee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9223 Belair Road, Baltimore, MD 21236 Theresa A. Carr, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/02/2009 Baltimore, Maryland Oaklawn Cemeterv 21. Signature of Funeral Service Licenses Leonard J. Ruck, Inc. avanage (R) 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ementia par disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by asteo abrasi 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ∐ Ýes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Hother (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after dearh.

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filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature an title of certifier Jan 100 completed cause of death (Item 23a) (Type, Molineuro MSCR 31. Date filed (Month, Day, Year) NOV - 3 2009 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

35280

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Maryland	should be fi and Mental H s marked of sumatic ever	Ø 8	19a. Informant's Name/Relationship	(Type. Print)	19b. Maili	ing Address (Street	and Number or Ru	ral Route Numbe	er, City or Towi	ı, State, Zip	Code)
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e e	item	13	20a. Method of Disposition	□	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	ce)	Date	20c. Location	- City or To	wn, State
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercitive must be notified at once.		21. Signature of Funeral Service Lice	enyée	The second secon	2. Name and Addre	as of Facility	radlev-	Ashto	n Fur	neral Home
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			30. Name and address of person wh	o completed cause of d	eath (Item 23a) (Type	Mam	11/220	1000	d. n	11)	21234
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380	Sta Regist		31. Date filed (Month, Day, Year)	32. Hegistra	ar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** DLUSHER 0 0 OHN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel 204 Emerson Avenue Glen Burnie | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 5, 1959 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** M 2□F 220-48-3001 50 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and: If item 27 is marked other than "natural", or items 23a or 28a-f show and: If item 27 is marked other than "natural", or hiems 23a or 28a-f show any or other traumatic event, I'ps. Medical Examiner in at the nutility of any other traumatic event, I'ps. Medical Examiner in at the nutility of any other traumatic event, I'ps. Medical Examiner in at the nutility of any other traumatic event, I'ps. Medical Examiner in a second content of the nutility of the second content of the nutility of 10d. Inside City Limits 10a, State 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21061 U.S.A. Completed by Funeral 204 Emerson Avenue 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No White Specify. Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) S.A.I.C. <u>Machanical Designer</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Albert Slusher Mary Narer ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Jacquelyn Slusher / Wife 204 Emerson Avenue Glen Burnie Maryland 21061 permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 2, 2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐Other (Specify) Atlantic Crematory 22, Name and Address of Facility Singleton Funeral & Cremation 21. Signat Eunera S **b**₁Z Services PA 1 2nd Ave.SW Glen Burnie MD 21061 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final neton **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to ininfiediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed Exami After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examiner and manner stated mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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State Registra

29b. Signature and title of certifier

and address of person who

E 31. Date filed (Month, Day, Year) 32. Registrar's gnatur

29c. License number

29d. Date signed (Month, Day, Year)

Stevens

Month

October

30

2009

12:00 PM

Physician /Medical **Funeral** Director 7 is marked other than "natural", or items 23a or 28a-f si traumatic event, the Medical Experiment rest be notified filed within 72 hours after death altimore, Maryland 21215-0036 Hygiene. and Mental Hygie Is marked other Health a 10

For State Registrar

Bryan

The law requires that the death certificate be executed physician and the burial-transi P.O. Box 68760, attending pl certificate has been signed by the rector, page 2 should be detached Division of Vital Records,

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Riverview Health Rehabilitation Baltimore Essex 9. Birthplace (State or Foreign Country) Virginia Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Months Hours Min. Days 1 🗓 M 2 🗆 F 223-24-8495 88 May 30,1921 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🛣 No Director MD Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Michael Avenue 21090 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. MYes 2 □ No Yes, Give 1 Never Married 2 Married Specify: White 1 ☐Yes 2 No Specify Completed by 3 ☐ Widowed 4 K Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Amusements 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Henry Bagsby Stevens Jeanette Elizabeth 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Ellen E. Craig/Daughter 305 Burwood Avenue Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 4, 2009 Glen Burnie, Maryland 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services PA 1 2nd Ave. SW Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician OU Known resulting in death) /Medical Due to (or as a consequence of) Examiner Krawn Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 **☑**1√0 1 □ Yes or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10-30-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASTERN BLUD, MD 21221. SEBNI 709. B 31. Date filed (Month, Day, Year) 2. Registrar's Signadure State 3 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 35284 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** STRATEMEYER 29, 11:05 PM DENISE **OCTOBER** 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE 8511 CHESTNUT OAK ROAD PARKVILLE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 🔽 F 2/10/1958 Director 213-70-3358 MARYLAND Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐XNo Director PARKVILLE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 8511 CHESTNUT OAK ROAD 21234 USA Funeral death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 Never Married XX Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. Specify: WHTTE þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) t of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ARTIST SELF EMPLOYED 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RUTH COX BASIL DRAKE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES A. STRATEMEYER/HUSBAND 8511 CHESTNUT OAK ROAD BALTIMORE, MD 21234 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place ō 1 ☐ Burial 2XXCremation 3 ☐ Removal from State permit. Page Department (Important: if any Injury or 11/3/2009 CATONSVILLE, MD METRO CREMATORY, INC. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MOO217 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest shock, or heart failure. List only one cause on each line. the. Immediate Cause (Finel Physician lear disease or condition resulting in death) /Medical Due to (or as a consequent of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 🗌 No 3 Probably 4 Unknown Completed -24b. Were autopsy findings evailable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 ☑ No director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only ne) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28b. Time of Injury 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 ☐ Pending investigation 1 atural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD Ste. 2200 Square Franklin 36 JV. 31. Date filed (Month, Day, Year) 32. Re State Registrar

AMEND_ITEM#9.10b.10e&19b.perFH.G897.11/5/09.WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 30. Physician/ 12:00 p M 2009 Kenneth R. Tucker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center Towson 9. Birthplace (State or Foreign Countring assachusetts Haryland 8. Date of Birth 7. Age (In yrs. last birthday) If Under 24 Hrs. 5. Social Security Number If Under 1 Year **Funeral** Min. 1 **X** M 2 □ F 577-28-7225 88 Director Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director Carroll Howard Maryland Marriottsville 1 🗌 Yes 2 🔀 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1320 Crows Feet Road Funeral 21104 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 \(\begin{align*} \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry **National** (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Security Agency Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward S. Tucker Mildred Jones 19b. Mailing Address (Troped Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) 1320 Crows Feet Road Marriottsville, Maryland 21104 Penny Vespa/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of October 2009 31, cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Metro Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Cremation Society of Maryland, 299 Frederick Road Baltimore, Inc. Maryland 21228 Alice Iser 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Castrio DOCK Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate

Cause (Disease or iinjury use as the burial-tran nding physician and that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death Yes 2 ☐ No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Who 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performe 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work' 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NOON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6:12 AM Physician/ Edward Calley Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Glans 05 9. Birthplace (State or Foreign Country) Virginia 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours 1 X M 2 □ F 1919 90 213-09-1891 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 No Essex Maryland

10e. Street and Number **Baltimore** 10g. Citizen of What Country? 10f. Zip Code Funeral United States 21221 407 Lorraine Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 XYes 2 No
If Yes, Give WW Black, White, etc. þ 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: WWII Completed 3 Widowed 4 Divorced White Year or Dates. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. Steel Industry Steelworker 7 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Elizabeth Thomas James Talley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Essex, Maryland 407 Lorraine Ave. Mrs. Carrie D. Talley (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of 1 Burial 2 Cremation 3 Removal from State Bel Air, Maryland 10/28/2009 4 ☐ Donation 5 ☐ Other (Specify) Air Mem. Gdns. Be1 21. Signature of Funeral Service Licenses. 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Dundalk, Maryland 7922 Wise Ave. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Lest only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to or as a consequence of: Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been also as a few points. attending physician and for use as the burial-tran resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Month Day Year in the past 12 months? Pregnant at time of death 2 No signed by the a Yes g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 6 X Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: To 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No (Month, Day, Year) 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 L Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 L Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D68286

State Registrar 31. Date filed (Month, Day, Year)

3 2009

555 Wes

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

09-08439 Joseph Tiburzi Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

e	Type of Fillicin bi	ack illuelible liik.	Elisare All Copics	7110
	State of Maryland	Department of He	ealth and Mental Hyg	iene

2009 35287

	1- For State Registrar	Certificate of	Death	Reg. No.	
Physician/ ledical Examine	Decedent's Name (First, Middle,Last)	Joseph	Tiburzi	2. Date of Death Month Day October 31, 2009	
	4a. Facility Name (if not institution, give street 1821 Merritt Blvd	et and number)	4b. City, Town, or Location of Death Dundalk		County of Death altimore County
Funeral Director	5. Social Security Number 6. Sex 220–24–0675 1 XM	7. Age (In yrs. last birthday) 2 F 79 Yrs	If Under 1 Year If Under 24Hrs Months Days Hours Min.		D/YYYY) 9. Birthplace (State or Foreign Country) MD
and 2 should be filed within 72 hours after death with the Maryland teath and Marial Hygina Marial Hygina Marial Hygina Marial Hygina Financial Farminer must be notified at once, traumatic event, the Medical Examiner must be notified at once.	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yee or Dr. 15. Decedent's Education (Specify only higher than 15. Decedent than 15. Decedent tha	Was Decedent Ever in U.S. Armed Forces? Yes 2 No 6, Give Year 1954–56 Implest grade completed) College (1-4 or 5+)	Dundalk 10f. Zip Code 21222 Is Decedent of Hispanic Origin? (Sirves, specify Cuban, Mexican, Puerto Yes 2X No specify: nt's Usual Occupation (Give kind of voost of working life. DO NOT use reti e Officer	Decify Yes or No-Rican, etc.) work done 16b. Kired) 186	en of What Country? ited States 14. Race - American Indian, Black, White, etc. Specify: White ind of Business/Industry altimore County v Enforcement Surname)
21215- ould be filed d Mental Hyg s marked oth itic event, the	Dominic Tuburzi_		Mar g Address (Street and Number or	ianna Ronto Rural Route Number, Cit	ondo ty or Town, State, Zip Code)
Baltimore permit. Pages 1 Department of H Important: If i	Mr. James D. Tibur 20a. Method of Disposition 1 XBurial 2 Cremation 3 R 4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	emoval from State 20b. Place of Disposorematory or of Sacred H 22.1	t. Of Jesus ¢em. Name and Address of Facility uda—Ruck Funeral 022 Wise Ave D	Date 20c. L 11/4/2009 Home of Duundalk, Mar	Dundalk, MD undalk, Inc.
Physician Medical xaminer		nshot Wounds of Head and Ch to (or as a consequence of):	est		Between Onset and Death
ecuted and transit	(Disease or injury that initiated events resulting in death) Last	to (or as a consequence of):			
the death certificate be executed by the attending physician and ched for use as the burial - transit	IF FEMALE: 23 23b Was decedent pregnant in the	Pregnant at time of death 5 C	etal death 3 Ectopic pregr		d. Date of delivery Month Day Year
P.C ss that ss that gened I be deta	5	tributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown 24b, Were autopsy findings available
Division of Vital Records, tal or Attending Physician: The law require as after death. al Director: After this certificate has been single in by the funeral director, page 2 should build in by the funeral director, page 2 should build by the funeral director.			Of Place of Death (Charle	autopsy performed?	prior to completion of cause of death?
ician:	25. Was case referred to medical examiner?	ital: 1 Inpatient 2 ER/Outpatier	26.Place of Death (Check nt 3 DOA Other Nurs		ence 6 🗸 Other: Scene
ion of Vital literath. tending Physician: earth. for: After this certif the funeral director.	1 Ves 2 No	28a. Date of Injury Oct 31, 2009 28b. Time of 0804 hrs	# 0 Box	28d. Describe how inj Subject shot self	ury occurred
Division ital or Attencurs after death ral Director:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, str. (Specify) Single Family Home	eet, factory, office building, etc.	28f. Location (Street a or Town, State) 1821 Merritt Blvd, D	and Number or Rural Route Number, City Dundalk, MD
	29a. Certifier 1 Certifying Physician: (Check only one) 2 Medical Examiner: On	To the best of my knowledge, death occ the basis of examination and/or investig	urred at the time, date and place, ar ation, in my opinion, death occurred	nd due to the cause(s) ar at the time, date and pla	nd manner as stated. ace, and due to the cause(s)
F. 3 F. 8	29b. Signature and title of certifier	ω)	29c. License number O.C.M.E.		Date signed (Month, Day, Year) vember 1, 2009
	30. Name and address of person who comp Laron Locke MD. Assistant		nn Street, Baltimore, MD 21	201	
Sta Registra	e 31. Date filed (Month, Day, Year)	2. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2120 Year October 2009 Arnold A. Turner 28 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) N/A Baltimore Union Memorial Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Numbe 7. Age (In yrs. last birthday) Months Days Hours **XX**M 2□ F 74 218-30-6558 1935 Maryland April 6, Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location 1 X Yes 2 No Baltimore N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21211 USA 315 W. Lorraine Avenue 12. Was Decedent Ever in U.S Armed Forces? 1 Dives 2 No If Yes, Give Year or Dates:1958 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify White 1 ☐ Yes XXNo Specify: 3 Widowed 4 XDivorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mele Metals Shear Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Elizabeth Kavanaugh Edward Edwin Turner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4215 Elsa Terrace, Baltimore, Maryland21211 Russell Turner Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Atlantic Crematory 11/3/09 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.21211 21. Signatur of Funeral Service Licens 3631 Falls Road, Baltimore, MD m 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, dy heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multisystem disease or condition resulting in death) Due to (or as a consequence of): Respienta Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ischer IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗹 No 2 🗆 No 1∏Yes 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

<u></u>

Funeral

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exp., it are must be muffied at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

and Mental Hygiene. Is marked other than

of Health a

Department of H Important: If Ite any injury or ot once.

altimore, Maryland 21215-0036

burial-tran ng physician as the burial attending p signed by the a cate has l certificate this

Examiner Physician/Medical Completed by Be Certification: To

the Hospital or Attending Physician: The law requires that the death certificate be executed Filled 24 hours within 24 hor To the Fune completely fi

Division of Vital Records, P.O. Box 68760,

s after death.

I Director: After this of in by the funeral d

State Registrar 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 5 Pending investigation 1 Natural 2 Accident 6 Could not be 3 ☐ Suicide determined 4 Homicide

29a. Certifier

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day, Year)

~ MD

28b. Time of

Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

AT 2438946

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) 10/23/2009

Baltimore, MD 21218

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 East University hris Jones

5

31. Date filed (Month, Day, Year) 3 2009

29b. Signature and title of certifier

32. Registrar's Signature

acks

			State of Maryland / De			giene			
			negisuai	ertificate of Death		Reg. No. 2009	35289		
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month		3. Time of Death		
	Medic	al	Eva Maria Thompson	T	October				
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location Aberdeen	n or Death	4c. County of Death Harford			
	Funeral		301 Irish Lane 5. Social Security Number 6. Sex _ 7. Age (In yrs. last birthday	If Under 1 Year If Under	er 24 Hrs. 8. Date of Birt	rth 9. Birthplace (State or Foreign			
	Director		577–40–7528 1 □ M 2XXF 88 Yrs.	Months Days Hours	Min. (Month, Day April 2	23, 1921 Austria			
_	d low	_	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or	ocation			10d. Inside City Limits		
	arytan a-f sh fied a	ecto	Maryland Harford Aberdeer				1 🗆 Yes 2 🛣No		
	or 28 or 28 e noti	声	10e. Street and Number	10f. Zip Code		10g, Citizen of What Cou	untry?		
	with t	Funeral Director	301 Irish Lane	21001	i i	U.S.A.			
	items items ier m	Fu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic O If Yes, specify Cuban, Mexico		14. Race - Amer Black, White			
36	after (I", or xamir	l by	1 Never Married 2 Married 3 X Widowed 4 Divorced 1 Yes 2 X No If Yes, Give Year or Dates.	1 ☐ Yes 2X No Specif	fy:	Specify: Whi	te		
ခု	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Completed by		edent's Usual Occupation		16b. Kind of Business I	ndustry		
215	n 72 h an "n Medi	립	(Specify only highest grade completed) (Giver Elementary/Seconday (0-12) College (1-4 or 5+)	e kind of work done during mo DO NOT use retired)	ost of working	Dept. of De			
7	withii giene rer th t, the		12 2 Se	cretary					
nd	filed ital Hy ed oth even	To Be	17. Father's Name (First, Middle, Last)	18. Mot Unk	ther's Name (First, Middle,	Maiden Surname)			
<u> </u>	uld be d Mer marke maric		Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Num		- City on Town State Zin	Cadal		
Ma	and 2 should be fil Health and Mental tem 27 is marked ther ther traumatic ew			Irish Lane, A			Code		
ē,	f Heal f Heal item		20a. Method of Disposition 20b. Place of Dis	position (Name of	Date	20c. Location - City or			
E O	Page 1 ment of ant: If it ury or o		1X Burial 2 □ Cremation 3 □ Removal from State cemetery, c 4 □ Donation 5 □ Other (Specify) Harford N	ematory or other place) Memorial Gdns.	11/4/2009	Aberdeen, M	Maryland		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Juneral Service Vice Isee	22, Name and Address of Fac Tarring—Cargo 333 S. Parke	Funeral Hom	e. P.A.			
<u> </u>	P S E E S		Jan James						
			23a. Part +: Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	12	~	rest,	Approximate Interval Between Onset and Death		
	Pnysician/ Medical			vascular	Disease		Officer and Dodge		
	Examiner		Due to (or as a consequence of):						
		ner	Sequentially list conditions, if any leading to immediate b. Due to or as a consequence of :						
	uted Id ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.						
	execian an	E E	resulting in death) Last Due to (or as a consequence of):						
9	iath certificate be executed attending physician and for use as the burial-transit	dical	d						
Box 687	ertifica ding p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of del	ivery		
ŏ	atten for us	iciar	in the past 12 months?	Ectopic pregnancy Other (specify)		Month	Day Year		
B	the de by the ached	hysi	1 Yes 2 No 9 Unknown						
P.O.	uires that the dea n signed by the a ld be detached f	by P	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Pa		obacco use contribute to	<u> </u>		
ds,	requires been sig should b	ted			1 📙	Yes 2 ☐ No 3 ☐ Pr			
CO	law re	Completed			24a. Was auto	psy prior to d	topsy findings available completion of cause of		
Re	hysician: The law his certificate has I I director, page 2 s				1 \ Yes	ormed? death? 2 No 1 Yes	2 🗆 No		
ita	sician certifi rector	Be c	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpa	Other	Peath (Check only one)		76.1		
) t	Physer this eral di	e: 1	27. Manner of Death 28a. Date of injury 28b. Time	of 28c. Injury at	Nursing Home 5 Resident Reside	now injury occurred	ny)		
uc.	ath. r: Afte	icat	1 Natural 5 ☐ Pending (Month, Day, Year) injur 2 ☐ Accident Investigation	/ work? M 1 ☐ Yes 2	□ No				
Division of Vital Records,	or Atte after de Directo in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (City or Tov	Street and Number or Rui vn, State)	ral Route Number,		
ă	urs af ral Di						A- 1		
	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my knowledge, deal of the basis of examination and/or in the basis of examination and the basis of e	estigation, in my opinion, death	occurred at the time, date a	and place, and due to the o	cause(s) and manner stated.		
	To the within 3	Σ	29b. Signature and title of pertifier	29c. License numbe		29d. Date signed (Month			
	- > - 0		M.D.	D 0063	981	11/2/2009			
	,		30. Name and address of person who completed cause of death (Item 23a) (Typ	D-i-t)	*		1078		
			31. Date filed (Month, Day, Year) 32. Registrar's Signature	utionSt., H	gure de Ural	e, up 2	1018		
	Sta Registr		NOV 0.2 2005 Phone A.	barket					
		_							

DHMH 17 Rev 7/2009

			1- State Amend Item 21 ^S	per fh,	g897	11 Pos Cei	riment of F rificate of I	lealth and I <i>Death</i>	Mental Hy	ygiene Reg. No	2009	35290
	Division		1. Decedent's Name (First, Middle, Last)						2. Date of D	eath Da	y Year	3. Time of Death
	Physicia /Medic		Josephine White-Sutt	on					Oct.	12		1400 hrs M
Por.	Examin	er	4a. Facility Name (If not institution, give street				4b. City, Town, or	r Location of Death	n		. County of Deat	h
			Howard County General 5. Social Security Number 6. Sex			st birthday)	Columbia If Under 1 Year	If Under 24 Hrs.	8. Date of B		oward	hplace (State or Foreign
	Funeral Director		295-26-6239 ^{1□ M}		. (III yi 3. Id	Yrs.	Months Days	Hours Min.	3/13/1	<i>ay</i> , Year)	OH Co	untry)
200	MC .		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
Mary	-f sho	to	Maryland Howard		Colur	nhia						1X Yes 2 No
4	r 28a	Directo	10e. Street and Number		COTUI	шота	10f. Zip Code			10g. Cit	tizen of What Co	untry?
th with	23a o ist be		5400 Vantage Drive				21044			U.S.A	A.	
1	ems	Funeral	11. Marital Status	Was Decedent E Armed Forces?	ver in U.S.	. 13. \	Was Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No Rican, etc.)	lo-	14. Race - Ame Black, White	
5-0036	to Health and Mental Hygiene. If flem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it is Medical Exemination in this date.	by	1 ☐ Never Married 2 ☐ Married	l ∐Yes 2 ⊠N fYes, Give ∕ear or Dates:	О		1 □Yes 2 No	Specify:			Specify: Whi	
215-0036	'natur	Completed	15. Decedent's Education (Specify only highest grade co	n mpleted)		(Give	dent's Usual Occup kind of work done	during most of wor	king	16b. K	ind of Business/	Industry
712 within	than	dmo	Elementary/Secondary (0-12)	College (1-4or 5-	+)		00 NOT use retired .strative	*	nt	Ceme	tery Va	ult Co.
Maryland 21	other other	a	17. Father's Name (First, Middle, Last)					18. Mother's Nan	ne (First, Middl	e, Maiden	Surname)	
<u> a</u>	Menta Irked Itic ev	To B	Frank Grupenhoff					Josephin	e Plogs	ted		
lar)	and Is me		19a. Informant's Name/Relationship (Type.	Print)			ng Address (Street					Zip Code)
6, ≥	of Health a ltem 27 is other trau		Jerry White/ Son		OOb Die		eclusion		Iineral :		23117 ocation - City or	Tawa Stata
	nent of h ant: If Ite		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 X Remo	oval from State		-	sition (Name of natory or other plac	i .			,	·
Baltimore,	Department of Important; If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee \(\)	lictor P		a. In 22	d Cemete: Name and Addre	ss of Facility			Richmon	
ñ	any any			per D		Ch 15	arles L. 01 East	Stevens Fort Ave	Funera nue, Ba	l Hor Itimo	me, Inc. ore, Mar	yland 21230
► PI	hysician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one commediate Cause (Final disease or condition	ons that caused ause on each lin	e.							Approximate Interval Between Onset and Death
	Medical xaminer		resulting in death)	Due to (or as a	•	ence of):						
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin. Cause (Disease or injury	Senility Due to (or as a		ence of):						
cuted	nd ransit	Examiner	that initiated events	Cardiomy	opatl	ny						
Ö,	cian al urial-t	EX	resulting in death) Last	Due to (or as a	a conseque	ence of):						
58760, ificate be executed	y physician and s the burial-transit	edical	d									
Geath cert	attending for use a	Physician/Me	in the past 12 months?	if yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify)	y			23d. Date of del Month	ivery Day Ye ar
7. that	ned by deta	by Ph	Part II. Other significant conditions contrib	uting to death bu	t not resul	ting in the u	nderlying cause giv	en in Part I.	23e. Dio	I tobacco	use contribute to	the cause of death?
ords, P.O	been signed by the								1 🗆]Yes 2	□ No 3□ Pi	robably 4 🔀 Unknown
The law	ate has page 2	Completed							per	s an opsy formed? 2 X No	prior to death?	utopsy findings available completion of cause of
OT VITA	certificate ector, pag	Be (25. Was case referred to medical examiner?		-		Lau	26. Place of Dea				
- ×	iši je	-T	1 ☐ Yes 2 ☒ No Hosp 27. Manner of Death	1 Inpatie		R/Outpatier 28b. Time of	nt 3 DOA Oth	4 LI Nursing F	tome 5 ☐ Re		6 ☐ Other (Spe	cify)
0 0	leath. tor: After this certific the funeral director,	tion	1 X Natural 5 Pending 2 ☐ Accident investigation	(Month, Day	(Year)	Injury	Worl	yat k? Yes 2 ∐ No	280. Describe	e now inju	ry occurred	
DIVISION or Attending	after deat Director: I in by the	ertification:	2 □ Putaida 6 □ Could not be	8e. Place of Inju building, etc	ry - At hon : (Specify)	ne, farm, str	eet, factory, office			(Street a		ural Route Number,
e Hospita	within 24 hours after death. To the Funeral Director: After the completely filled in by the funera	edical C	29a. Certifier 1 Certifying Physicia (Check only one) 2 Medical Examiner:		examinati							
To the	To the	Me	29b. Signature and title of certifier	11/1	no		29c. Licens	se number		29d. Da	ate signed (Mont	h, Day, Year)
			1 Pun De	1			D5398	7		Oct.	14, 200)9
	5		30. Name and address of person who complete Kenneth N.A. Geh, M	D , 300	Armo	ry Pla	ace, Suit	e 3G, Ba	1timore	, MD	21201	
Œ	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 3 2005	32. Registra	ir's Signatu	1. 4	ares					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g897 11-3-09 vt. State of Maryland / Department of Health and Mental Hygiene amend #18&19b Per FH G8977 11 61 Death JH 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** B Womble Ernest 30 11-30 AM 2009 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**√** M 2□ F Months 78 214-26-0151 Director 09 05 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director MD NΔ Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 5303 Haddon Ave U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. XYes 2 ☐ No f Yes, Give ∕ear or Dates: 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Mayors Office of College (1-4or 5+) 2yrs lementary/Secondary (0-12) Compliance Baltimore City 18. Mother's Name (First, Middle, Maiden Surname)

Marian other traumatic event, 17. Father's Name (First, Middle, Last) Be ould be f Joseph B. Womble Deane Marion and l 1353 Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5503 Haddon Ave, Baltimore, Md 21207 Evelyn Womble-Wife If Item 27 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other

Deane Family Pages 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Injury or Department of Important: If any Injury or 11/7/09 Cumberland, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as the attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9∏Unknown 9 Unknown certificate has been signed irector, page 2 should be def Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown COPD Completed TIA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform ARTHRITIC 1□ Yes 2. No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of centifier 29c. License number 29d. Date signed (Month, Day, Year) MD Res 000 2009 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

NOV 0 3 2009

SAYED KAZI

31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/2001

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DHMH 17 Rev 1/2001

		- R	State Registrar				Certificate of L	Jeain		Reg. No.	2009	354	93		
Dhysici	an		cedent's Name (F						2. Date of Dea Month October	Day	Year	19:40	P ^M		
Physici /Medi			Vera Pat					Leasting of Dooth	October		County of Death				
Exami	ner	4a. Fa			street and number)		Parkv	Location of Death		40.	-	altimore			
· ·		5 500	244 / Wo	odcroft		(In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da	h Your	9. Birth	nplace (State o	or Foreign		
Funeral Director			16–12–987	4.0	□ M 2□ X	87 Yr	Months Davs	Hours Min.	July 30	192	,1922 Maryland				
pu 🔏		Usual 10a. S	Residence of De	cedent b. County		10c. City, Town of	or Location					10d. Inside Ci	ty Limits		
Maryla if sho	lo		MD	Balti	more		Parkville					1 □Yes	¾ □No		
r 28a	Director	10e. S	Street and Numbe	er			10f. Zip Code			10g. Cit	izen of What Co	untry?			
h with			2447 Wo	odcroft	Road		2123				JSA				
deat	Funeral	11. M	larital Status		12. Was Decedent E Armed Forces?	ver in U.S.	 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	•	 Race - Amer Black, White 				
21215-UU36 I within 72 hours after death with the Maryland giene. I than "natural", or items 23a or 28a-f show the Mariles I s	by Fu		☐ Never Married ☑ Widowed 4 ☐		1 □Yes 2 □XN If Yes, Give Year or Dates:	0	1□Yes 2▼No	Specify:			Specify:	white			
5-0036 72 hours aff natural", or			15	5. Decedent's Ed	ucation	16a. [Decedent's Usual Occup	nation	(ina	16b. K	ind of Business/l	Industry			
within 72 iene. than "na"	Completed	Ele	ementary/Seconda	only highest gradery (0-12)	College (1-4or 5-	+)	Give kind of work done of the contract of the	i)		At I	Home				
0 2 0 .	ြီ	47.5	12 Father's Name (Fin	rot Middle Last)			Homemaker	18. Mother's Nam	e (First, Middle	Maiden	Surname)				
and z	ag eg	1		M. Batt	-on				. Miller						
Maryla d 2 should th and Mer T is marke traumatic	မြ	199	. Informant's Name			19b. I	Mailing Address (Street				or Town, State, 2	Zip Code)			
tra = Z			rry Dadd		_		5 Circle Ro								
attimore, N mit. Pages 1 and portment of Health portant: If item 27 y injury or other toe.		20a.	Method of Dispos	sition Cremation 3 🗆	Removal from State	20b. Place of I cemetery.	Disposition (Name of crematory or other place thedral	ce) !	Date 4,2009		ocation - City or timore, N		đ		
Baltimo permit. Page Department Important: If any injury o			4 Donation 5 Signature of Fune		_	Ceme	tery 22 Fiame and Addre Evans Fune	ess of Facility	al and ("rem	ation Se	ervices	112-1		
a med med a			Condi	se LT	ME Ferold		8800 Harfo	ord Road-	Parkvil.	le,M	aryland	21234			
Dhyoloign	ą.	Imm	shock, or heart f nediate Cause (Fir	failure. List only	one cause on each iir	ie.	ot enter the mode of dyin		or respiratory a	arrest,		Approxima Interval Be Onset and	tween		
Physician /Medical	•	dise resu	ease or condition ulting in death)		a. Due to (or as	a consequence of):	Chil							
Examiner		Segi	wentially list condi	itions.	b. ASC	UD									
ed sit	a di	if an	uentially list condi by, leading to imme se. Enter Underly ise (Disease or inj	ediate ring	Due to (or as	a consequence of	VE CARDI	31/48/16	1 40 1	Vica	40,55				
execut and and	Fyaminer	that resu	initiated events ulting in death) Las	_	c. Due to (or as	a consequence of	D: CARDA	CVIISCY		121	1)30	-			
68760, ifficate be executed g physician and as the burial-transit	legipa			•	d										
68 rtificat ng phy as th			FEMALE:					· · · · · · · · · · · · · · · · · · ·							
Box 6 leath certifi attending	Dhyelelan/M	23b.	. Was decedent p in the past 12 m			2 Fetal death	3 Ectopic pregnan	су			23d. Date of de Month	elivery Day	Year		
P.O. E nat the degraph of the a letached for	0	S S	1 □Yes 2 kg1 9 □ Unknown		4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 ☐ Other (specify) _	-							
ds, P.O. I lires that the de signed by the a d be detached fo	6	Part	II. Other significa	ant conditions	contributing to death b	ut not resulting in	the underlying cause gi	ven in Part I.	23e. Did	tobacco	use contribute t	o the cause of	death?		
rds quires n sign	1	<u> </u>							1 🗆	Yes 2	2 No 3 P	Probably 4 🗆	Unknown		
Vision of Vital Records, P.O. Box E Attending Physician: The law requires that the death certificath. It death. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	potologo								_ perl	opsy formed?	prior to death?	utopsy findings completion of s 2 □ No	s available cause of		
tall			Was case referre	d to medical				26. Place of De	1 □Yes ath (Check only		10 1 111	8 2 1140			
Vii sicla s cert		י מ	examiner? 1 ☐ Yes 2 🛣 N		Hospital: 1 ☐ Inpati	ent 2 ER/Ou	tpatient 3 DOA Ot	her: 4 \(\sum \) Nursing I	Home 5 Res	sidence	6 □Other (Sp.	ecify)			
on of ling Phy I. After thi funeral of	1	27.1	Manner of Death 1 ☑ Natural	5 ☐ Pending investigatio	28a. Date of Inju (Month, Da		ime of 28c. Injury Wo	uryat ork? ⊡Yes 2⊡No	28d. Describe	how inj	ury occurred				
Division of Vital Records, To the Hospital or Attending Physician: The law requires t within 24 hours after death. To the Funeral Director: After this certificate has been signs completely filled in by the funeral director, page 2 should be	10.01914	<u> </u>	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	e 28e. Place of Ini	ury - At home, far c. (Specify)	m, street, factory, office		28f. Location City or Te	(Street a	and Number or F ite)	Rural Route Nu	imber,		
Div To the Hospital or within 24 hours afte To the Funeral Dir completely filled in			(Check only 2	Certifying P	miner: On the basis (of examination an	, death occurred at the d/or investigation, in my	time, date and place opinion, death occ	e, and due to the curred at the time	e cause e, date a	(s) and manner and place, and du	as stated. ue to the cause	e(s)		
thin 24 the F		29a	one) o. Signature and ti		and manner st	ated.		nse number			Date signed (Mor		_		
5 ≥ 5 0		200	In	4 15	Palmina	i fraci	D DO	9475		11	1-02-0	9			
12V			and the same of th		completed cause of		(Type, Print) M / S	122 HARI	FORD RI	5.	BALTIM	OBRP 1	1214. 4D.		
121 State Registrar 120 Annul A. Salmurani fruid D09475 11-03-09 11-03-															

09-08444 Vivian C. Wood Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/ivian C. Wood		State of Maryland / Department of Certificate of I		d Mental H		. No. 20	09 3529	
Physician	/ 1	egistrar I. Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death	
Medical Examine		Vivian C. Wood		To the County	Month October 31	, 2009 4c. County of De	1115 hrs	
	4	ia. Calify ratio (if not instituting give and	Glen Burnie	Location of Death	l	Anne Aruno		
Funeral	1.5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Yea	r If Under 24Hrs	8. Date of Birth	(MM/DD/YYYY) 9.	Birthplace (State or Foreign	
Director			Months Day	s Hours Min		3. 1928 P	Country) ennsylvania	
		Jsual Residence of Decedent			1 CD . 2	1020 11		
v any		10a. State 10b. County 10c. City, Town or Location	n				10d. Inside City Limits 1 Yes 2 No	
land f show	<u> </u>	Maryland Anne Arundel Glen Burni			110	g. Citizen of What C		
he Maryla or 28a-f	ည် 1 မ	10e. Street and Number	10f. Zip Code					
r death with the Maryland or tiems 23a or 28a-f sh must be notified at onc		7975 Crain Hwy. S. #317 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	21061	spanic Origin? (S	Decify Yes or No-	nited Sta 14. Race - Ar	tes nerican Indian, Black,	
eath w	luer	1 Never Married 2 Married Armed Forces? If Ye		n, Mexican, Puerto		White, et	c.	
fiter de li't, or		3 X Widowed 4 Divorced If Yes, Give Year	Yes 2 X No			Specify: Wh	ite	
uatura xamir	<u>a</u>	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent'during mo	s Usual Occupa	ation (Give kind of	work done tired)	16b. Kind of Busine	ess/Industry	
16 n 72 h nan "n ical E	ompieted	Elementary/Secondary (0-12) College (1-4 or 5+)						
Within the the the	Ē	12 Homemal 17. Father's Name (First, Middle, Last)	ker	18. Mother's Name	e (First, Middle, M	Own Home laiden Surname)		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	D P	James M. Rupert		Martha				
ould b	0	19a. Informant's Name/Relationship (Type, Print)	Address (Stre	et and Number or	Rural Route Num	ber, City or Town, S	State, Zip Code)	
MD and 2 sho alth and 2 is aumati	L	Sandra J. Wood / Daughter 734 5			. Sever:	na Park, 20c. Location - Cit	Md 21146	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation 3 Removal from State crematory or oth	er place)					
time t. Pag tment rtant:		4 Donation 5 Other Specify: Glen Have	n Mem. 1	Park 11	/6/2009	Glen Bur	nie. Maryland	
Bal Bermi Depar Impo injur	- 1	21. Signature of Fineral Service Usensee (NU) 3 (0 (1.43)	rkley-Ri	uddick F	uneral H	ome, P.A.	D 21061	
Physician	1	23a. Pan I. Enter the disease, or complications that caused the death. Do not enter the	e mode of dying	g, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and	
/Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive cardiova	scular	disease			Death	
xammer		or condition resulting in death) Due to (or as a consequence of):						
	ا _ق	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):						
	틹	Compare Service of the Compare						
108 E 2011	EX	d						
SO, So, So, So, So, So, So, So, So, So, So	edical Examiner	X UNPENDED X AMENDED 28f, permE g901 23a, PI, 27, 28a	3/17/10	O TT	1/15/10			
certificate be e		IF FEMALE: 23c. If yes, outcome of pregnancy	I-T PETII			23d. Date of de	· ·	
tox 6876 eath certificate at the transfer as t	Physician/M	past 12 months?	al death 3 ner (Specify)	Ectopic pregr	nancy	Month	Day Year	
Box death death)Sic	1 Yes 2 No 9 Unknown	ier (Opecny)					
		Part II. Other significant conditions contributing to death but not resulting in the u		given in Part I.			te to the cause of death? Probably 4 Unknown	
S, P uires th n signe	ed by	Dementia; fracture of right humerus	<u> </u>		24a. Was		re autopsy findings available	
ord: w req as bee	plet				autop	sy pric	or to completion of cause of	
Rec The la	Completed				1 ✓ Yes		Yes 2 No	
ician:	e Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient		Other Nurs		Residence 6	Other:	
of Vi	유	1 ✓ Yes 2 No Injury 2 ENGURATION 221. Manner of Death 28b. Time of Injury (Month, Day, Year)		jury at Work?		how injury occurred		
on Conding ath.	틸	1 Natural 5 Pending (Month, Day, Year)	1	Yes 2 X No	unk			
VISION Attender in by t	Certification:	28e. Place of Injury - At home, farm, street	et, factory, office	building, etc.	28f. Location (Street and Number	or Rural Route Number, City	
Dival pital o	틽	determined (Specify) nursing nome			RI Gles	a Burnie:	-Mn 2/00 S.	
te Hos n 24 hu le Fun letely		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur (check only one) 2 Medical Examiner: On the basis of examination and/or investigat	red at the time,	date and place, a	nd due to the caus d at the time, date	se(s) and manner a and place, and due	s stated. e to the cause(s)	
To th Vithin	Medical	2 Medical Examiner: On the basis of examination and/or investigate and manner stated. 29b. Signature and title of certifier		nse number			(Month, Day, Year)	
	-	Quada Santa and and an activities		C.M.E.		November 1		
D 2"7	-	30. Name and address of person who completed cause of death (Item 23a)			-			
Other		Ana Rubio MD. Assistant Medical Examiner 111 Penn S		nore, MD 212	01			
Sta	ile.	31. Date filed (Month, Day, 1999) 32. Registrar's Signature	7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Trezevant Player Yeatman Jr.III 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ D01 November 2009 2:43 1CATMAN-Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Prince Georges Washington Adventist Hospital . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 XM 2 F Days Director 413-94-7954 57 Tennessee Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho 10d. Inside City Limits Director MD Prince Georges College Park 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20740 7305 Dickinson Avenue U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1

X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Writer Writing Department of Health and Mental Hygi important: If item 27 is marked othe any injury or other traumatic event, it is the context. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nancy McDearman Trezevant Player Yeatman, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3344 Properity Ave., Fairfax, VA. 22031 Ruth Kriz/Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place)

Ardent Cremation Services 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 11/02/2009 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ardent Cremation Services and C. Hardesty MOH9 21076 7522 Connelley Drive, Ste.N, Hanover, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Due to (or a consequence of: disease or condition resulting in death) Medical Examiner Shock Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) signed by the attending physician and detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year ☐ Yes ∠ ☐ ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Yes 2 📈 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident within 24 hours after death To the Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Scriftying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) #67953 MD foress of person who completed cause of death (Item 23a) (Type, Print) MOTHURAGE ADVENTISH HOSPITAL 31. Date filed (Month, Day Year) NOV 0 3 2009 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** William Riley Asbury, Jr. 6:50 P. M October 17, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, YOUR SEP. 13, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Year 1**X** M 2 □ F 66 1943 West Virginia Director 233-68-4600 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Evan, item must be notified at Yes 2 No Director Gaithersburg Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 42 Dalamar Street #1 United States permit. Pages 1 and 2 should be filed within 72 hours after death bepartment of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items 23 any injury or other tranmatic event, its Medical Exy, narroual any injury or other tranmatic event, its Medical Exy. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: White ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Landscaping 9 Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cora Frances Warrix William Riley Asbury, Sr. ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11501 Dewey Road, Silver Spring, MD 20906 Roger L. Asbury, Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State OCT. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) Atlantic Crematory 2009 Glen Burnie, MD 21. Signature of Fuperal Service Licenses 22. Name and Address of Facility
Thibadeau Mortuary Service, P.A. M0956 933 Gist Ave., LL, Silver Spring, MD 20910 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIORESPIRATORY ARREST disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ESOPHAGEAL CARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown 9 Unknown signed of Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? certificate 1 ☐Yes 2 XNo 1 ☐Yes 2 X No this certifical director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2k∏ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Makan musty my OCTOBER 18, 2009 62562 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MD 20850 MADHAVI HUBBLY, M.D. 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9:09am Consolata Amatucci October 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital 8. Date of Birth (Month, Day, Year) 09 / 14 / 1910 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. Italu 99 Director 215-82-7280 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show ir than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No Director Silver Spring Maruland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 520 Randolph Road 20904 U.S.A. death v Funeral 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify ₽ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any Injury or other traumatic event, the Mental Once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Teresa Tirella ဥ Severino Nazzaro 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3527 Todds Lane, Olney, Maryland 20832 Samuel Amatucci. Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3-☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 10/21/2009 | Silver Spring, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Linensee A100709 11800 New Hampshire Ave., Silver Spring, MD20904 23a. Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction day /Medical Due to (or as a consequence of) **Examiner** Coronary Arteriosclerosis if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of). Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 💆 No Month 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>Ş</u> Emphysema 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? Asthma 24a. Was an 2 🛛 No 1 ☐ Yes 2 ☐ No Congestive Heart Failure 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 X No 1 ☐ Inpatient 2 🛱 ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c 28d. Describe how injury occurred spital or Attending P nours after death. neral Director: After t y filled in by the funera Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital
within 24 hours a
To the Funeral I
completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0002338 October 20. 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Richard Delaney,

OCT 21 2009

31. Date filed (Month, Day, Year)

M.D..

32. Registrar's Signature

3929 Ferrara Drive, Wheaton, Maryland 20906

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Mary Elizabeth Albero 13,2009 October 10:25 Å /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 87 Stewart Drive unit #2 Edgewater Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 112-28-5502 71 Director 01/11/1938 Bronx NY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. Counfy 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD Anne Arundel Edgewater 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 87 Stewart Drive unit #2 'natural", or items 23a 21037 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Maritai Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White ģ Specify: 3 Widowed 4 X Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Inventory Supervisor Automotive Department of Health and Mental Hygic Important: If item 27 Is marked other any Injury or other traumatic event, tt once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Kiernan Beatrice Scanlon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank R. Albero 5290 West Valleyside Court Virginia Beach VA 23464 Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ST. Raymonds Cemetery10/19/2009 4 ☐ Donation 5 ☐ Other (Specify) Bronx, NY 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 851 Annapolis Road Gambrills,MD 21054 Data Hardesty Funeral Home P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** West /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant et time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2☐ 3☐ Probably 4☐ Unknown has been signed 2 should b 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate ha autopsy performe 1∐ Yes 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Natural М 1 ☐ Yes 2 ☐ No thours after death.

Cuneral Director: A

ely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check o 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) onel manner stated 29b. Signature and 29d. Date signed (Month, Day, Year) 80. Name and address of State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Robert Smith Bourbon, Sr. 2009 October 19, 10:40^Mp 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice-Casey House Rockville Montgomery 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days Hours Year) Months 1 X M 2 □ F Min. 220-20-5145 20, 1928 Maryland Feb. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3561 S. Leisure World Blvd. Apt. 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married If Yes, Give Year or Dates: 1946-48 1 ☐Yes 2 😿 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Attorney Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) August James Bourbon Gertrude Reilly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20906 Margaret A. Bourbon/Wife 3561 S. Leisure World Blvd., Apt. 2B, Silver Spring, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Oct. 23 2009 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Brain Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 5 Other (specify) 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

Directo

Funeral

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Completed

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item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Evanter must be notified at

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ould be filed within 72 hours after death v Mental Hygiene. arked other than "natural", or items 233

permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic er

Baltimore, Maryland 21215-0036

with the Maryland

/Medical

burial-tran and attending physician for use as the buria signed by the a cate has t certificate

certificate be

P.O.

Division of Vital Records,

Examiner Physician/Medical þ Completed Be After this of funeral dire Certification: To

To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Hospital or Attending Physician:

Diabetes Mellitu	ıs,	Congestive Heart Fa	iluı	re		1 ☐ Yes 2 [No 3☐ Probably 4☐ Unknown
						24a. Was an autopsy performed? 1 □Yes 2 🖔 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No
25. Was case referred to medical examiner?				26. Place of De	ath (Check only one)	
1 Yes 2 No	H	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 🗆 DC	OA Other: 4 \sum Nursing	Home	5 ☐ Residence 6	X Other (Specify) Hospice
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigat	ion	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	M 2	8c. Injury at Work? 1 □ Yes 2 □ No	28	d. Describe how injury	occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		28e. Place of Injury - At home, farm, street building, etc. (Specify)	, factory	, office	28	f. Location (Street and City or Town, State)	f Number or Rural Route Number,
29a. Certifier 1 Certifying	Phys	ician: To the best of my knowledge, death or ler: On the basis of examination and/or inves	ccurred	at the time, date and place	e, an	d due to the cause(s)	and manner as stated.

29b. Signature and title of certifier J. Kouertchou;

D63748

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyne Kouatchou, MD 1355 Piccard Drive, Rockville, MD 20850

and manner stated.

October 20, 2009

State Registrar

Medical

31. Date filed (Month, Day, Year)

21



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Oct. 2009 2:10P M Helen Baker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Bradford Oaks Nursing Home Clinton 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) Funeral 1 □ M 2**X** Days Hours Month, Day, Year 1 / 3 0 / 1 6 Virginia Director 578-32-8288 93 Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No MD Prince George Upper Marlboro 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5605 S, Marwood Blvd. Apt. 402 20772 USA tems death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", 3X☐ Widowed 4 ☐ Divorced Completed Black Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Computer Specialist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Carter Birdie Lee Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Baker/Son Brandywine Rd. Brandywine, MD 20613 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Maryland National 10/16/09 | Laurel, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Latney's Funeral Home, Inc. 21. Signature of Funeral Service Licensee 3831 Georgia Ave.NW Wash.,DC CC278 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examir Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death the 9 Unknown 9 Unknown been signed by should be detact Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page 2 this certificate 1 ☐ Yes 2 ☐ No rector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred irector: After 1 Natural
2 Accident
3 Suicide
4 Homicide work? 1 ☐ Yes 5 Pendina 2 🗆 No death. Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, fter determined building, etc. (Specify) within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Civingh Rond 11701 isan

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.? 2. Date of Death 1. Decedent's Name (First, Middle, Last) Blackmon Physician /Medical Oc tober ranklin 15 2009 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) Nov. 17, 1977 Birthplace (State or Foreign Country) If Under 1 Year If Under 5. Social Security Number 7. Age (In vrs. last birthday) . Sex 1 M 2 ☐ F **Funeral** Months Days Hours 216-11-9066 Maryland 31 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show 3a or 28a-f shov be notified at 1 ☐ Yes 2X No Director Dover Kent 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code USA 23a 19901 1894 Windswept Cir. Funeral Was Decedent Ever in U.S. Armed Forces?

1

X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2X Married 5 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: Specify:Black ģ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) marked other than Elementary/Secondary (0-12) Soldier U.S. Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Janet Louise McKay Franklin Curtis Blackmon, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau once. Christine Lynn Hall Blackmon 1894 Windswept Cir. Dover, DE 19901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Arlington Nat'l Cem. 10-27-09 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service censee 22. Name and Address of Facility Beall Funeral Home Bowie, MD 20715 6512 NW Crain Hwy. 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one sause on each line Immediate Cause (Final bacterial Physician meningitis disease or condition /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Dav filled in by the funeral director, page 2 should be detached for in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 1 Yes 2 □ No မ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) n 24 hours after o 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

OCT 19 2009

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31. Date filed (Month, Day, Year)

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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back

RES 000

10-15-2009

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Yea **Physician** 0 2009 ctobe /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Came Mende Ra Linthicum Anne Asunde If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth (Month, Day, Dec 16 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Oklahoma 17⁄2 M 2□ F 83 515-12-0672 1925 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modeal Examilian must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 931 Edgewood Rd. Apt 214 21403 USA by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Mayes 2 □ No if Yes, Give Year or Dates: 1,960 – 80 within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) 8th Postal Mail Carrier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be fi es 1 and 2 should be of Health and Menta Item 27 is marked Wyatt M. Bailey Sr Cozie Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Ross(Son) 2803 Tamarind Rd. 21209 Baltimore, Md. 20c Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of Inportant: If Ite 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran 10-16-09 Crownsville, Md. 21. Signature of Funeral Service Licensee Amname Reduces of Sacilisons Mortuary, P.A. 821 West St. Annabolis, Md. 21/01 M00483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each live. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause and underly cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of) Box 68760, the attending physician death certificate be Physician/Medical the SS IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō Month 5 ☐ Other (specify) 0 □Yes 2□No 9 Unknown 9 Unknown signed by t d be detach σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No fo the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) SZĘNO Other: 4 Nursing Home 5 Residence 6 Other (Specify 10) 104 How P 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

1x1 D

> State Registrar

ical

29a. Certifier

(Check only one)

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

OCT 19 2009

a and address of person who completed cause of death (Item 23a) (Type, Print)

300 Registrar's Signature

Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 9 Physician/ 9:10 Рм 2009 Philip L. Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis 3502 Narragansett Ave If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 6. Sex 8. Date of Birth Funeral Davs Jan 16 1 ★ M 2 □ F Maryland 1909| Director 100 213-12-4047 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 28a-f Maryland Anne Arundel Annapolis 1 Yes 2 X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a death with 21403 3502 Narragansett USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Anne Arundel Co. Elementary/Seconday (0-12) College (1-4 or 5+) 12th 6yrs Vice Principal Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William H. Brown Julia A. Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, Md. 21403 Rachel H. Brown(Wife) 3502 Narragansett Ave 20a. Method of Disposition 20b. Mace of Disposition (dame of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Memorial Gardens 10-16-09 Annapolis, Md. 4 Donation 5 Other (Specify) M Mame and the composition of Facility Sons Mortuary, 21. Signature of Funeral Service Licensee Lan 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner 104000 Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events consequence of -transit Exami Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 the attending ploces to the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 No 9 Unknown Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown Completed page 2 should Deen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perfori death? 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 2 100 1 🗌 Yes 4 Nursing Home ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) te Hospital or Attending Plin 24 hours after death.

The Funeral Director: After the funeral Director of the funeral pleted filled in by the funeral pleted filled in by the funeral pleted filled in by the funeral filled i 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury Accident Suicide Investigation 3 ☐ Suicide 4 ☐ Homicide within 24 hours after de To the Funeral Directo completed filled in by th 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occ curred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title License number 29d. Date signed (Month

DHMH 17 Rev 7/2009

State Registrar se of death (Item 23a) (Type

09-07880 Clayton Boston Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of He I-For State Certificate of De		Reg. No.	200	0 2520				
Physicia dical Exami	an/	Decedent's Name (First, Middle,Last)	2.	Date of Death Month Day October 10, 2009	Year	1820 hrs				
		Clayton Boston 4a. Facility Name (if not institution, give street and number) 4b. Cit	y, Town, or Location of Death		County of Death					
			en Burnie	Ar 8. Date of Birth (MM/D	ne Arundel	ning (State on				
Funeral Director			nder 1 Year If Under 24Hrs. nths Days Hours Min.	12/19/195	Transina	Maryland				
nd show any ice.	۲	10a. State 10b. County 10c. City, Town or Location 10d. Anne Arundel Glen Burnie				10d. Inside City Limits 1 Yes 2 No				
vith the Maryland s 23n or 28n-f show a	Director	10e. Street and Number 10f. 7900 Benesch Circle # 842	Zip Code 21060	10g. Citize	en of What Count	ry?				
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tent and Mental Hygiene. tent 27 is marked other than "natural", or items 23a or 28a-5 sho tranmatic event, the Medical Examiner must be notified at once.	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, sp	edent of Hispanic Origin? (Spec ecify Cuban, Mexican, Puerto Ri	can, etc.)	4. Race - Americ White, etc.	an Indian, Black,				
hours afte "natural", Examiner	ত্র	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usi	2 X No specify: ual Occupation (Give kind of wor working life. DO NOT use retired	k done 16b. Ki	nd of Business/In	dustry				
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21215-(uld be filed : Mental Hyg marked oth	Be	Kenneth Earle Boston	Mabel Cr		,					
ID 2's should and Marice	٤	19a. Informant's Name/Relationship (Type, Print) Carpathia Boston / Sister 19b. Mailing Addr 229 Gros	ral Route Number, Cit Polis, MD		Zip Code)					
nore, MD ages 1 and 2 sh nt of Health an nt: If item 27 i		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Hope Application (1) The Property of t	Date 20c. L	ocation - City or T	·					
Baltimore, MD 2 permit. Pages I and 2 should Department of Health and M Important: If item 27 is m injury or other traumatice.		4 Donation 5 Other Specify: Methodist Cr	nurch Cemetery and Address of Facility anco & Sons, P.	2009	lgewater					
_	4	23a. In the Enter the disease, or complications that caused the death. Do not enter the mo	50V. RILCHIE HW	y, Severna	a Park, I	MD 21146 Approximate Interval				
Physician /Medical		failure. List only one cause on each line. Immediate Cause (Final disease a, Atherosclerotic Cardiovascular Disease		espiratory arrest, snot	x, or near	Between Onset and Death				
xaminer		or condition resulting in death) Due to (or as a consequence of):								
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated								
cuted nd transit		events resulting in death) Last Due to (or as a consequence of): d.								
7 60, cate be executed physician and he burial - transit	Medical	UNPENDED AMENDED								
3876 rtificate ing phy as the b	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de	ath 3 Ectopic pregnanc		. Date of delivery Month D	ay Year				
Box 6876 death certificate he attending phy	Physician/	1 Yes 2 No 9 Unknown g Unknown	Specify)	-		15				
ires that the c signed by th	þ	Part II. Other significant conditions contributing to death but not resulting in the under	ying cause given in Part I.	1		he cause of death?				
Records, The law require ficate has been si, page 2 should b	Completed			24a. Was an autopsy performed?		opsy findings available ompletion of cause of				
tal Rection: The certificate ector, page		25. Was case referred to medical	26.Place of Death (Check on	1 Yes 2 No	1 ✓ Ye	s 2 No				
of Vital ng Physician: Of the certil	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	Other		nce 6 🗸 Other	Scene				
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Division spital or Attendit ours after death. teral Director: A	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, fact (Specify)	tory, office building, etc. 2	8f. Location (Street a or Town, State)	nd Number or Ru	ral Route Number, City				
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.								
F \$ F 8	Re	29b. Signature and title of certifier	29c. License number		Date signed (Mor					
NH		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	Octo	ober 11, 2009	,				
2	-	Margarita Korell MD. Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 2	1201						
S: Regis	tate trar	31. Date filed (Month Day, Year) 2009 32. Segistrar's Signature S. Sank	J							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 26, 1:20 A.M Ivalee Broadwater 2009 October 0 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 302 Spring Lane Rd. Oakland Garrett If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 27 F Director 217-10-1565 95 Sept. 15 1914 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Funeral Director MD 0akland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 302 Spring Lane Rd. 21550 United States Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ Specify 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Benjamin Campbell Phillips Amanda Alberta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Stewart, Daughter 302 Spring Lane Rd., Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of IImportant: If ite
any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Deer Park Cemetery 10/29/2009 Deer Park, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550 Katherine 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Demon **Physician** schemic eav disease or condition resulting in death) /Medical Due to (or es a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) ng physician a as the burial Physician/Medical signed by the attending be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Dav 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autonsy perform 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 | Yes 2 | ₩6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 TAccident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide

Division of Vital Records, P.O. Box 68760, ours after death.
neral Director: A
filled in by the fu within 24 hours a

To the Funeral C

completely filled

> State Registrar

DHMH 17 Rev 1/2001

29a. Certifier

OC Danie 31. Date filed (Month, Day, Year)

2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year,

FACURES ON Oakland MD 2155

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Saac Daniel ctober 18 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9. Birthplace (State or Foreign is Anne Arundel Medical Center napo Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 1 M 2 □ F Maryland Months Days Hours Min. 216-70-5958 March 13 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or liems 23a or 28a-f show any injury or other traumatic event, the Medical Experiment per notified at once. 1 ▼Yes 2 No **Funeral Director** Centreville veen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2924 61 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 PNo If Yes, Give Year or Dates: Specify þ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Specialist MachineManufacturing 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Katie ၉ Mes Felton)a 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Park Road Centre ville, Maryland 2/6/7
of Date 2002 Location - City or Town, State Harriett 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Centreville, Marylone 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses MD.216 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiple Myeloma **Physician** > luh disease or condition resulting in death) /Medical Due to (or as a donsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) signed by the attending physician and be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ To the Hospital or Attending Physician: 17th tawn required within 24 hours after death.

To the Funeral Director: After this certificate has been signed the Funeral Director. After this certificate should I 3 Probably 4 Ûnknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 npatient 2 ER/Outpatient 3 DOA မှ 1 ☐ Yes Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name

31. Date filed (Month

d address of person

mp

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1) 280

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10 Month 18 Day 2009 **Physician** 5:05 P M William Harlan Breedlove /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester 11526 Country Club Dr. 21811 9. Birthplace (State or Foreign Country)
T I If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth 9/29/1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** IL 1 X M 2 □ F 82 314-24-0640 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State show ed other than "natural", or items 23a or 28a-f shov event, the Wedical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director MD Berlin Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21811 USA 11526 Country Club Dr. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 🕅 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Research Analyst US Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harlan Floyd Breedlove Mary Ryan ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11526 Country Club Dr., Berlin, MD 21811 Joanne Breedlove / wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/22/2009 Cape Henlopen Crem. Frankford , DE 4 ☐ Donation 5 ☐ Othey (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral & 108 William St., Berlin, MD 21811 0 Part I. Enter the "sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each like. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** oronary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner sit any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Year Day 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be To the Hospital or Attending Physics within 24 hours after death.

To the Funeral Director: After this ce completely filled in by the funeral direct Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide I/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

841 1241

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

29c. License number

29d. Date signed (Month, Day, Year)

10.19.2009

			1 _ State	of Maryland / De	epartment of F Certificate of I			0000	25200
			Registrar 1. Decedent's Name (First, Middle, Last)		Jerimoate or t		2. Date of Death	. No. 2 1 9	3. Time of Death
	Physicia /Medic		Sarah France	es Brown			October	Day Year 15, 2009	7:40 p M
	Examin		4a. Facility Name (If not institution, give street and 401 Concord Apartmer			Location of Death		4c. County of Deat	
i	Funeral		Social Security Number	7. Age (In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birt	thplace (State or Foreign
ı.	Director		264-54-5418 1 M 2 X	F 70 Yr	s. Months Days	Hours Min.	March 25,	าี้ 939 ซึ	irginia
	yland yland		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location		_		10d. Inside City Limits
	ne Mar 8a-f sl	Director	Maryland Cecil		Perryville)			1X Yes 2 No
	with the	I Dire	10e. Street and Number : 401 Concord Apartment	c	10f. Zip Code	21903	10g	. Citizen of What Co	•
	death	Funeral	11 Marital Status 12. Was [13. Was Decedent of H If Yes, specify Cuba		ecify Yes or No-	14. Race - Ame	erican Indian,
36	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Exp. of ser must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes	es 2X No Give	1 □Yes 2 □ No	Specify:	nicari, etc.	Black, White	White
15-0036	2 hour		15. Decedent's Education	or Dates:	ecedent's Usual Occup	ation	16	b. Kind of Business/ .A. Medic	
121	vithin 7 ne. han "n	Completed		le (1-40r 5+)	Give kind of work done of ife. DO NOT use retired				al Center t, Maryland
2	al Hygie other t	Be Co	17. Father's Name (First, Middle, Last)	Years Li	censed Prac		(First, Middle, Ma		c, maryrand
ylan	should be and Mental s marked o umatic eve	To B	Robert James	Walker		0rv	a Gay Da	1 ton	
Maryland 2	12 sho th and 7 is ma traums		19a. Informant's Name/Relationship (Type. Print) Suzanne Brown (daug		Mailing Address (Street May		•		Zip Code) 903
	ages 1 and 2 should be ant of Health and Mental t: If item 27 is marked o y or other traumatic eve	8.4	20a. Method of Disposition	20b. Place of D	Disposition (Name of crematory or other place	<u> </u>	ate 20	c. Location - City or	Town, State
Baltimore,	Pages ment of ant: If its ury or o		1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	R.A.Fer	ris & Co.,	[nc.¦ 10/2		st Cheste Pennsyl	
Rail	permit. Pages Department of Important: If i eny Injury or once.		21. Signature of Funeral Service Licensee	5. mm 5	22. Name and Addre Lee A. Pa Peri	ss of Facility tterson &	Son Fune	ral Home,	P.A.
ı		30-1	23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause	at caused the death. Do no					Approximate Interval Between
	Physician /Medical		resulting in death)	TASTATIC L		CAR			Onset and Death
	Examiner		/ u	to (or as a consequence of)		ULHOW AVE	DISEA	ie l	YEARS
	ed sit	iner		to (or as a consequence of					
,	execut n and ial-tran	Examin	that initiated events	to (or as a consequence of));				
98760	eath certificate be executed attending physician and for use as the burial-transit	edical	d						
_		/Mec	IF FEMALE: 23c. If yes	outcome of pregnancy				23d. Date of de	livory
O. Box	death cert ne attendin ed for use a	Physician/M	in the past 12 months?	ive birth 2 Fetal death regnant at time of death Inknown	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	y 		Month	Day Year
٦. ا	hat the d by th	Phys	9 ☐ Unknown Part II. Other significant conditions contributing		he underlying cause giv	en in Part I	23e Did toba	cco use contribute to	o the cause of death?
Vital Records,	w requires that the de been signed by the should be detached	d by	-		andonying educe giv				robably 4 Unknown
9 9	faw rec as bee 2 shou	Completed					24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
E S	sician: The fav certificate has rector, page 2 s						performe 1 ☐ Yes 2 [d? death?	2 No
=	/siciar s certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital:	I ☐ Inpatient 2 ☐ ER/Outp	nationt 3 DOA Oth	ar.	n (Check only one)	ce 6 ☐ Other (Spe	ocife)
Division of	ng Phy ifter thi	$\Vdash_{\mathcal{I}}$	27. Manner of Death 28a. D	ate of Injury 28b. Tir			28d. Describe how		outy)
1810	kttendl death. ctor: A y the fu	icati	2 Accident investigation 3 Suicide 6 Could not be	face of Injury - At home, farm		Yes 2 □No	28f Location (Stre	et and Number or R	ural Route Number
<u>≥</u>	al or A s after il Direct	Certification:	4 ☐ Homicide determined	uilding, etc. (Specify)	i, street, lactory, office		City or Town,		arai rioute vuinibei,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filed in by the funeral director,	ledical (29a. Certifier 1 Certifying Physician: To (Check only one) 2 Medical Examiner: On t						
	To the within To the comple	Med	29b. Signature and title of certifier	marrier stated.	29c. Licens	e number	290	I. Date signed (Mon	th, Day, Year)
			1 y no		000,	ווררו	٥	ctober a	10,2009
	5		30. Name and address of person who completed DAN VO GAR-EL 304	-306 North	Street Su	tt #3 E	LKTON y	ARYLANI	0 31921
			31. Date filed (Month, Day, Year)	2. Registrar's Signature					
	Sta Registr		OCT 2 1 2009	2. Registrar's Signature	back				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

Months

7. Age (In yrs. last birthday,

77

Yrs.

10c. City, Town or Location

4b. City. Town, or Location of Death

Charlotte Hall

Hours

If Under 1 Year | If Under 24 Hrs.

17,

2009

St. Mary's

4c. County of Death

Supplies and Distribution

10:45 P.

10d. Inside City Limits

9. Birthplace (State or Foreign Country)
Phila., Pa.

October

8. Date of Birth (Month, Day, Year) 05/07/1932

1	Physicia /Medic Examin	al
	Funeral	

1 - State Registrar

5. Social Security Number

578-42-6611 Usual Residence of Decedent

Edward Louis Bland, Jr.

Charlotte Hall Veterans Home

6. Sex

1**∑** M 2□ F

4a. Facility Name (If not institution, give street and number)

10b. County

Director 23a or 28a-f show

ith with the Mary 23a or 28a-f sh	Director	Md.	P.G.		Largo)				1 TarYes 2 □ No
or 28	Sire	10e. Street and N	umber			10f. Zip Code		10g. 0	Citizen of What Co	ountry?
th wit	a L	108	06 Woodlawn	Blvd.		20774			U.S.A.	
r dea	Funeral	11. Marital Status	12	. Was Decedent E Armed Forces?	Ever in U.S. 13	B. Was Decedent of I	Hispanic Origin? (Specify Yes oan, Mexican, Puerto Rican, e	or No-	14. Race - Ame Black, White	
5-0036 72 hours after death with the Mary "matural", or items 23a or 28a-1 sh	þ		ried 2 Married 4 Divorced	1 Yes 2 In Yes, Give Year or Dates:	53-'73	1 □Yes 2 No				lack
	Completed	(Spe	15. Decedent's Educa ecify only highest grade of ondary (0-12)	tion completed) College (1-4or 5	(Gir	cedent's Usual Occu ve kind of work done . DO NOT use retire	during most of working	16b.	Kind of Business/	Industry
d 2121 filled within Hygiene. other than "	ပ်	12th				anager				d Distribut
Maryland 212- 12 should be filed within h and Mental Hygiene. r is marked other than raumatic event.	To Be		(First, Middle, Last) d Louis Bla	nd, Sr.			18. Mother's Name (First, I		en Surname)	
			Name/Relationship <i>(Type</i> C. Bland/Wi				t and Number or Rural Route wn Blvd.,Largo		or Town, State, 2	Zip Code)
			sposition ☐ Cremation 3 ☐ Rer 5 ☐ Other (Specify)	noval from State	1	position (Name of rematory or other pla	i .		Location - City or	
Baltimo permit. Page Department of	SDICE:		uneral Service Licensee	. 0,		22. Name and Addre H.S.	Washington & S	Sons C	. Myer, ' o.,Inc.	
Dhuaisi		23a. Part 1. Enter shock, or he Immediate Cause	the disease, or complica art failure. List only one	cause on each lin	the death. Do not e ie.	enter the mode of dy	oughs Ave N. I	E Was tory arrest,	hington,	Approximate Interval Between Onset and Death
Physicia /Medic Examin	al er	disease or condit resulting in death	f a	Due to (or as a	PEIMER a consequence of):	(2 4)	SEASE			
Box 68760, sath certificate be executed attending physician and for use as the burial-transit	dical Examiner	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease of that initiated even resulting in death)	S C.		a consequence of):				()	
O. Bc he death the atter	Completed by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1: 1 □ Yes 2 9 □ Unknow	2 months?	. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	B ☐ Ectopic pregnand ☐ Other (specify)	су		23d. Date of del Month	livery Day Year
cords, P. w requires that to be signed by should be detacted.	d by Pł		ificant conditions contri NTIAL				ven in Part I. 23e			o the cause of death? robably 4 Tunknown
I Rec Telaw at has b	Complete							. Was an autopsy performed?	death?	utopsy findings available completion of cause of
f Vital ysician: T	e e	25. Was case reference examiner?	Tites	spital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpati	ient 3 □ DOA Oth	26. Place of Death (Check	only one)		ecify)
ion of ading Phy th. : After this	tion: T	27. Manner of Dea	th 5 ☐ Pending investigation	28a. Date of Injur (Month, Day	y, Year) 28b. Time Injury	Wo			ury occurred	
Division al or Attending s after death. I Director: After	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Inju building, etc	iry - At home, farm, s :. <i>(Specify)</i>	street, factory, office	28f. Loca City	ition (Street or Town, Sta	and Number or Ru te)	ural Route Number,
Division of V To the Hospital or Attending Physic within 24 hours after death. To the Funeral Director: After this ce completely filled in by the funeral direct	Medical C	29a. Certifier (Check only one)	Certifying Physic	ian: To the best of r: On the basis of and manner sta	examination and/or	ath occurred at the t investigation, in my	ime, date and place, and due opinion, death occurred at the	to the cause time, date a	e(s) and manner a and place, and due	s stated. to the cause(s)
To the complex	Ž	29b. Signature an	title of dertilier			29c. Licen:			Date signed (Mont	
			unkino,	, MI	>	DE	7788		10.19.	2009
R10+		30. Name and add	ress of person who com				Hall Rd.,Cha	rlotte	Hall,Md	1.20622

DHMH 17 Rev 1/2001

Registrar

OCT 2 1 2009

State of Maryland / Department of Health and Mental Hygiene

		_	For State Registrar	Otate of Marylan		rtificate of l		Re	g. No. 2009	35310
	Physici	an	1. Decedent's Name (First, Middle, La. Norma Arce Com	st) eford				2. Date of Death October	19, 2069	3. Time of Death 2:40 р м
*	/Medic Examin		4a. Facility Name (If not institution, giverally 10430 Haywood Dr	e street and number)	<u> </u>		Location of Death Spring		4c. County of Death	
	uneral irector		481-48-4798	ex 7. Age (In yrs. 78	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 5,	Year) 9. Birth Cou Phi	place (State or Foreign Intry) lippines
Maryland	a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Montg		y, Town or Lo	cation Spring				10d. Inside City Limits 1 K Yes 2 □ No
th with the	23a or 28 ust be no	Funeral Director	10e. Street and Number 10430 Haywood D	rive			0902		usa	
:1215-0036 within 72 hours after death with the Maryland	Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show withingt or other traumatic event, the Medical Examinat must be notified at once.	by Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 😿 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 _ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 🛣 Yes 2 🗌 No		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White, Specify:	
21215-0036 od within 72 hours aft	ne. nan "natur Medical	Completed by	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of work d)	ing	6b. Kind of Business/li	ndustry
land 21	lental Hygler ked other th ic event, the	To Be Con	17. Father's Name (First, Middle, Last, Pedro Arce	5+		Tax Pre		e (First, Middle, M ad Sahagu		
Maryland	alth and M 27 is mar r traumati	ř	19a. Informant's Name/Relationship (Patricia A. Come		19b. Mailii 773	ng Address <i>(Street</i> l Unionwo	and Number or Rui od Drive,	al Route Number, Midvale	City or Town, State, Z	ip Code) 47
Baltimore,	ment of Hea ant: If item ury or othe	3	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	cemetery, cřel	osition (Name of matory or other place itan Crem	ce) Oc	t. 20.	20c. Location - City or T	
Balt permit.	Import any inj once.		21. Signature of Funeral Service Lice	Cola	2:	Francis 500 Unive	ී ^{of F} C©1lin rsity Blv	s Funera d. W., S	l Home Inc Silver Spri	ng, MD 2090
//	ysician /ledical aminer		23a. Part 1. Enter the disease, or come shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence)	f The l		ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Cnset and Death
68760, tificate be executed	physician and the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or Injury that initiated events resulting in death) Last	c						
Box death cer	attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	☐ Ectopic pregnand ☐ Other (specify)	zy		23d. Date of del Month	ivery Day Year
ords, P.O	been signed by the chould be detached	by	Part II. Other significant conditions	contributing to death but not res	sulting in the u	ınderlying cause giv	ren in Part I.		es 2 No 3 Pr	the cause of death? obably 4 \textstyle Unknown
Rec	has le 2	Completed						24a. Was ar autops perforn 1 🗆 Yes 2	v I prior to o	topsy findings available completion of cause of
of Vita Physician:	certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		-t all poal Oth		th (Check only one	e)	
o E	g: 22.	<u>ان</u>	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date of Injury	28b. Time o	nt 3 DOA	4 LI Nursing H		ence 6 Other (Sperior occurred	cify)
Division	after death. Director; After th I in by the funeral	Certification:	1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year)	Injury ome, farm, st	M 1 🗆	kî?]Yes 2□No	28f. Location (St.	reet and Number or Ru	ıral Route Number,
Div	within 24 hours after of To the Funeral Direct of completely filled in by		4 ☐ Homicide determined	building, etc. (Speci	owledge, dea	th occurred at the t	ime, date and place	City or Town	ause(s) and manner a	s stated.
he Hos	in 24 h he Fun ipletely	edical	(Check only 2 ☐ Medical Exa	miner: On the basis of examin and manner stated.	ation and/or i	nvestigation, in my	opinion, death occu	rred at the time, d	ate and place, and due	to the cause(s)
_	Verthin 2 To the complex	Ž	29b. Signator and title of certifier Rabert H	Sheard Mi	D	29c. Licens	D55522	2'	9d. Date signed (Monte	
'			30. Name and address of person who				oad. Silva	er Sprine	g, MD 20910)
¥	Sta Regist		31. Date filed (Month, Day, Year) OCT 21 200	3. Registrar's Sign			,	-T -PITH	5, 110 2001	

DHMH 17 Rev 1/2001

\$

6. Sex 1 ☐ M 2 ☐ F

52

1. Decedent's Name (First, Middle, Last)

218-66-4959

4a. Facility Name (If not institution, give street and numbe

Physician /Medical

Examiner

Funeral

Director

Year)

1957

2. Date of Death

MD

8. Date of Birth (Month, Day,

Feb.

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

SPRING

Min.

SILVOR

Days

Maryland

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ☐ Yes 2 🛣 No

4c. County of Death

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

4 Unknown

MONTGONGER

	-	1	Usual Residence of De	ecedent											
	show		10a. State 10	0b. County		10c. City	, Town or Loc	ation						10d. Inside City L	.im
	a-fs	cto	MD I	Prince C	eorge's	Lan	ıham							1 □Yes 2	XI
	h the	ire	10e. Street and Number	er				10f. Zip C	ode			10g. C	itizen of What Co	ountry?	
	th wit	Funeral Director	9346 Anna	polis Ro	l .			20	706			Ü	ISA		
	ems	ne	11. Marital Status		12. Was Decedent 8 Armed Forces?	ver in U.S	S. 13. W	as Deceder Yes, specify	t of Hisp	anic Origin? (S Mexican, Puer	pecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, Whit		
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show after Exartinat be notified at	by Fu	1 ☐ Never Married 3 ☐ Widowed 4 B	90	1 XYes 2 □ N If Yes, Give Year or Dates:	lo		□Yes 2		Specify:	,		Specify:	White	
2-0	72 hou 'natura	eted		5. Decedent's Edi only highest grad	ucation de completed)		16a. Decede	ent's Usual (Occupation Cone duri	on ing most of wo	king	16b.	Kind of Business	/Industry	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene, item 27 is marked other than "natural"; or items 23a or 28a-f shoo other traumatic event, If a Medical Examinational be motified at	Completed by	Elementary/Seconda		College (1-4or 5	+)		o not use uck Di					Constru	ction	
ğ	othe	Be C	17. Father's Name (Fir	rst, Middle, Last)					18	3. Mother's Nar	ne (First, Middle	e, Maide	n Surname)		
<u>a</u>	wild be i Mental arked o atic eve	10 B	Franklin	D. R. C	awley				1	Margare	t E. Ral	be			
ary	2 should and Men is marke aumatic	-	19a. Informant's Name	e/Relationship (7	ype. Print)		19b. Mailing	Address (S	Street and	Number or R	ural Route Numi	ber, City	or Town, State,	Zip Code)	
	1 and 2 Health a tem 27 is		Margaret 1	E. Cawle	y / mothe:	r	9346	Annapo	olis	Rd.	Lanham,	MD	20706		
Baltimore,			20a. Method of Dispos		Removal from State	20b. Pl	ace of Dispos emetery, crem	ition (Name atory or othe	of er place)		Date	20c. I	Location - City or	Town, State	
Ĕ	nit. Pages artment of ortant: If its injury or o		4 Donation 5 l			Ft.	Linco	ln Cer	netei	cv 10/	21/2009	Br	entwood	, MD	
alt	permit. Page Department of Important: If any injury or once.		21. Signature of Fune	ral Service Livens	see		22.	Name and	Address	of Facility B	eall Fu	nera	l Home		
_	20 E # 9		//ev	1			6	512 M	V Cra	ain Hwy	. Bowie	e, M	ID 2071!	5	
			23a. rar 1. Enter the shock, or heart fa	dis ase, or comp	lications that caused one cause on each lin	the death	. Do not ente	r the mode	of dying,	such as cardia	c or respiratory	arrest,		Approximate Interval Betwee Onset and Dear	n
7	Physician		Immediate Cause (Findisease or condition	nal	a CEREP	ROV	KSWI	AR	Ac	CIDEN)2			Onset and Dear	th
1	/Medical		resulting in death)		Due to (or as	a consequ	ence of):								
	Examiner	_	Sequentially list condit	tions.	b		EUMO	NIK							
	ed sit	Examine	Sequentially list condit if any, leading to imme cause. Enter Underlyi Cause (Disease or inju- that initiated events	ediate ing	Due to (or as	a consequ	ence of):								
	xecut and I-tran	хап	that initiated events resulting in death) Las	_	c Due to (or as	a consequ	ence of):								
60,	be ey ician burla	E E	,		Due to (or as	a consequ	choc ory.								
87	icate phys s the	gig			d										_
O. Box 68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent print the past 12 mo 1 □ Yes 2 □ N 9 □ Unknown	onths?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🔲 Fetal	death 3	Ectopic pre Other (spec					23d. Date of de Month	elivery Day Yea	ır
σ.	that the de led by the detached	H.	Part II. Other significa	ant conditions co	ontributing to death bu	ut not resu	Iting in the un	derlying cau	se given i	in Part I.	23e. Did	tobaccc	use contribute to	o the cause of deat	h?
rds	w requires to been signal should be a	Completed by			<u> </u>						1 🗆	Yes	2 □ No 3 □ P	Probably 4 Unk	no
၁၁	law re as be 2 shc	plet									24a. Was	s an opsy	24b. Were a	utopsy findings avai	ilal
Ě	The Late has page	E O									perf 1 □ Yes	ormed?	death?	s 2 □ No	
ïta	ician: The certificate ector, pago	Be (25. Was case referred examiner?	/						6. Place of De	ath (Check only	one)			_
>	Physic this co		1 ☐ Yes 2 ☑ No				ER/Outpatient		Other:		lome 5 ☐ Res	sidence	6 ☐ Other (Spe	ecify)	
on c	ng the liner	tion:	27. Manner of Death 1 Natural 2 □ Accident	5 ☐ Pending investigation	28a. Date of Inju (Month, Day	ry /, Year)	28b. Time of Injury	28c	. Injury at Work? 1 ∐ Yes	t s 2 □No	28d. Describe	how inj	ury occurred		
Division of Vital Records,	I or Attendi after death. Director: A d in by the fu	ertification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injubuilding, etc	ıry - At hoi c. <i>(Specify</i>	me, farm, stre	et, factory, o			28f. Location City or To	(Street a	and Number or R te)	Rural Route Number,	,
											1				

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6

29c. License number

P State Registrar

52)

Medical Certification: To

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director: After this certificate ha completely filled in by the funeral director, page

29b. Signature and title of certifier

31. Date filed (Month, Day,

Year)

29a. Certifier

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** October 23, Lester Culp 2009 5:01 A^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett County Memorial Hospital Garrett 0akland Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min Months 1 □ M 2 □ F 234-42-9659 Director 95 Maryland July 20 1914 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at M∐Yes 2 □ No Director MD Garrett Mtn. Lake Park 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21550 601 L Street Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates þ Specify Specify: 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nrt: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Saw Operator Saw Mill 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Culp Lula Hill ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 117, Bayard, WV 26707 Charles Culp, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 10/27/2009 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oakland, MD Garrett Memorial Gardens 22. Name and Address of Facility
David A. Burdock Funeral Home, P.A. 21. Signature of Funeral Service Licensee Katherine 21 N. Second St., Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed in burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year signed by the a 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 st 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The 1 ☐Yes 2 ☐No 1 ☐ Yes **Division of Vital** director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 →No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral d 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who empleted cause of death (Item 23a) (Type, Print) 311 N. Fourth Street, Suite 1, Oakland, MD 21550 Kenneth Buczynski, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 27 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1556 Carlos David Camacho-Ruiz Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Easton Memoria albot Easton 8. Date of Birth (Month, Day, Year) 6, 1963 If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 🛛 M 2 🗆 F Puerto Rico 581-27-8874 Months Days Hours 46 Director Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director Talbot Easton 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25818 Moore's Road 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Narried Completed by Baltimore, Maryland 21215-0036 1 🖎 es 2 ☐ No Specify: Puerto Rican If Yes, Give Year or Dates Specify: Puerto Rican 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) foundry welder 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evence. Angel Luis Camacho Martinez Maria D'Los Angeles Ruiz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yolanda Camacho wife 25818 Moore's Road, Easton, MD 21601 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/24/09 Richards Mem. Park Easton, MD 21. Signature AfaFuneral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. Cambridge, MD 700 Locust St 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ pato ce disease or condition youth Medical resulting in death) ^rExaminer Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury physician and s the burial-transit that initiated events resulting in death) Last Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant : 9 Unknown Dav Pregnant at time of death as been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law autopsy perform page 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner? **Division of Vital** the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 2 XNO မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioner: To the best of my knowledge. Seath conversed at the films lead, and claim, and due to the namebility of dimension as states 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTON, M 2160/ S. Wash PAUL W. MONTE

Registrar

31. Date filed (Month, Day, Year)

OCT % I

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William Albert Campbell, Sr. Ctober 0004 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Washington County Hospital Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F 220-28-3208 74 0271771935 Director MDUsual Residence of Decedent 28a-f shov 10b. County 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rral", or items 23a or Examiner must be r Funeral 312 N. Prospect Street 21740 US within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: **Black** "natural", 3 X Widowed 4 □ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education permit. Page 1 and 2 should be filled within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machine Operator Truck Manufacture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Albert Eugene Campbell Jame Ellen (Dorsey) Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Karen E. Burnett / Daughter 312 N. Prospect Street, Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Rose Hill Cemetery 10/26/2009 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) cancer Medical **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy perform this certificate Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes မ 1 🛂 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b, Time of 28c. Injury at 28d. Describe how injury occurred neral Director: After filled in by the funer 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral I Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

-H8+1 State

 Date filed (Month, Day, Year) 2009 Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of

eath (Item 23a) (Type, Print)

29d. Date signed (Month. Day, Year)

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			For State	State of Ma	aryland / [t of He <i>e of D</i> e		/lental H	lygien Reg. N		0	35315
	-		Registrar 1. Decedent's Name (First, Middle, Last)			Cert	IIICale	e or Di		2. Date of I	Death	200		3. Time of Death
	Physici /Medic		Fred Merl	e Colema	n					October 18, 2009 3:44 a				
	Examir		4a. Facility Name (If not institution, give street 603 Chapel Terra				-		ocation of Death e de Gra		40	c. County of D	eath arfo	nd
	Funeral		Social Security Number 6. Sex	7. Ag	e (In yrs. last bir	thday)_	If Under	1 Year	f Under 24 Hrs. Hours Min.	8 Date of	Birth	9.		ce (State or Foreign
	Director		102-22-7377	1 2□F	78	Yrs.	Months Days Hours Min. (Month, Day, Year) Country) Dec. 26, 1930 Pennsy					nsylvania		
	yland now		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Loca	ation	· · · · · ·					100	d. Inside City Limits
	e Mary Ba-f sh	ctor	Maryland Harford			ŀ		de 0	Grace					1 □ Yes 2X□ No
	th with th	Funeral Director	10e. Street and Number 603 Chapel Terra	ce			10f. Zip	2107	' 8		10g. C	itizen of What	S.A.	y?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Modical Eyn, it is at rust by routify of once.	by Fune	11. Marital Status 12 1 □ Never Married 2 ☼ Married 3 □ Widowed 4 □ Divorced	. Was Decedent I Armed Forces? 1 XYes 2 ☐ I If Yes, Give Year or Dates:		1	as Deced Yes, spec □Yes 2		panic Origin? (Si Mexican, Puerto Specify:	pecify Yes or Rican, etc.)	No-	14. Race - A Black, W Specify:		c.
15-0	72 ho "natur	leted	15. Decedent's Educat (Specify only highest grade of	tion completed)	16a.	Decede	ent's Usua	al Occupati k done dur	on ring most of work	ding	16b.	Kind of Busine	ess/Indu	1 Guard
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pd	al Hyg I other	BeC	17. Father's Name (First, Middle, Last)						8. Mother's Nam	- 1		,		
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	and 2 shealth and 127 is ner traun		19a. Informant's Name/Relationship (Type Waldtraut Q. Coleman						race, H					21078
nore	ages 1 ent of He it: If iten y or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	20b. Place of cemeter.	and .	Mamai	rial	10/2	Date 23/09	Abo	-ocation - City rdeen ,	Max	nyl and
Baltimore,	permit. F Departme Importar any Injur	1	21. Signature of Funeral Service Licensee	THEN	m < c	Gard Le	ens Name and ee A.	d Address Pati	of Facility terson & yville,	Son F	uner	al Hom	e F	2.A.
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each lir	a consequence	of):	r the mode	e of dying,	such as cardiac	or respirator	y arrest,	21903-	ĺĺí	Approximate Interval Between Onset and Death
68760,	be executed ician and ourial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence AMSI (W a consequence M. C	1	11.70))						
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. For the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bompletely filled in by the funeral director, page 2 should be detached for use as the bound in the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	i. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death		Ectopic pi Other (sp				_	23d. Date of Month		y Day Year
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Division of Vital Records,	sician: The law requir certificate has been s rector, page 2 should	Completed by)							24a. W au pe 1 □ Ye	topsy rformed?	prior deat	r to com	sy findings available pletion of cause of 2 2 100
Vit	slclan: The certificate irector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	spital:	ent 2 ☐ ER/Ou	uta atio at	2	Other	6. Place of Dea	•		C [] Other (0	
on of	fing Phy o. After this funeral d	ion: To	27. Mann f Death 1 □ Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry 28b.	Time of njury		8c. Injury a Work?	4 🗆 Nursing 🗆	A		ury occurred	Specify)	
Division	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ury - At home, fa c. (Specify)	rm, stree			S 2	28f. Location City or	Street a Town, Sta	and Number o	or Rural	Route Number,
	e Hospi 24 hour e Funer detely fill	Medical	29a. Certifier (Check only one) 1 CertifyIng Physic 2 Medical Examine		f examination ar									
	To the within to the complex c	M	29b. Signature and title of certifier HISWSW	n			29c	License r	Tymber L		29d. D	ate signed (M		Pay, Year)
	31		30. Name and address of person who com	pleted cause of d	eath (Item 23a)	(Type, P	rint)	Mo	76 1	ND	210	378		
		State Registrar 31. Dake filed (Month, Day, Year) OCT 2. 1 2009 Author B. Sank												

B. parks

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avis Cross		1- For State	tate of	Maryla	and / I		rtment of <i>tificate of</i>			Menta	al Hyg		Reg. No.	20	09	3531
									2. Date of Death			Year	3. T	ime of Death		
edical Examir										October 2		09		325 hrs		
		4a. Facility Name (if not institution, give street and number) Old Trappe Lane					4	4b. City, Town, or Location of Death Avenue			Death	4c. County of Death St. Mary's				
Funeral		5. Social Security Number	6. Sex		7. Age (In yrs. la	st birthday)	If Under 1 Year If Under 24Hrs.			8. Date of Birth(M		MM/DD/YYYY) 9. Birthplace (State or			
Director		218-35-3158	1 x M	M 2 F 17 Yrs			Months Days Hours Min.			Min.	May 28, 1992		32	Country	istrict of ⁾ Columbia	
		Usual Residence of Decedent														
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MD ad 2 shoulth and m 27 is aumati		Thomas Edwin Cro	ss, Jr	. / Fa	ther		39655 1							, MD 2065		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mentel Hygiene. I ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 Crematic	n 3	Removal fr	om State		lace of Dispos rematory or oth		e of ceme			Date er 30,		Location - City		
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xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):														
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Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical Examiner	X UNPENDED														
760, cate be physic he bur		IF FEMALE:		23c. If yes,	outcome	of pregr	nancy						23	3d. Date of deliv	ery	
68 certifi	ian	23b. Was decedent pregnant in past 12 months?		1 Live t		ne of dea	nth -	tal death	3	Ectopic p	pregnan	су	- Į	Month	Day	Year
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Specify Tound in truck Avenue, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mone) 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and manner stated.																
The state of the s										signed (Month, Day, Year)						
									tober 28, 20	009						
	30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201															
Sta		31. Date filed (Month, Day, Year	2000	32 R	egistrar's	Signatu	bar	K)								

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35317 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Day 8. 2009 Gladys Marie DiMeglio 7:42 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country Illinois 1 🗆 M 2 🗓 F Min. July 03. 1919 Director 341-12-1259 90 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Montgomery Silver Spring Maruland 10e. Street and Number 10g. Citizen of What Country? Funeral 20901 U.S.A. 704 Kerwin Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify. Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Carl Norman Dora Tippi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 East High Bluff Dr., Hampstead, NC 28443 <u> Joyce E. Lopez - Daughter</u> 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Heaven Cem. 10/24/2009 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 11800 New Hampshire Ave., Silver Spring, MD20904 23a. Part 1. Enter the disk a shock, or hear ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Carrie (Final Physician/ Lytracodomino disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner stamo Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Aff
d in by the fur 2 Accident
3 Suicide
4 Homicide Investigation To the Hospital or Atter within 24 hours after de To the Funeral Directo completed filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Bobby Stanley David, M.D.,

DYTTIY

7610 Carroll Ave., Suite 270, Takoma Park, MD 20912

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Raymond Dail October 0 19 2009 12:45 James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1430 Foxtail Lane Prince Frederick Calvert 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F Months Director 82 246-26-4642 11-26-1926 Florida Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at Director 1 □Yes 2 No MD Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1430 Foxtail Lane Funeral 20678 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 \ \ Yes 2 \ □ No If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Specify. \$ Specify: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event. In a second once. 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 carpenter construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Quince Dail. 2 Shollar 5 4 1 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Sheldon, daughter 1430 Foxtail Lane, Prince Frederick, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 10-19-09 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) COStecte cancer Menth /Medical Due to (or as a consequence of) Examiner enal free Sequentially list conditions if any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a nonsequence of) -transit that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year Day signed by the at the detached for 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy 1 ☐ Yes 2 No 1 ☐ Yes the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? of or Attending Patter death. 28d. Describe how injury occurred 1 Natural 5 Pending Iniury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) completely filled in by 4 Homicide within 24 hours a

To the Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

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3altimore, Maryland 21215-0036

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Division of Vital Records,

Physician:

Registrar

30. Name and add

31. Date filed (Month, Day, Year)

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

238 Merrince

Bruce Deal	ricade Type of Time in Diagram and an area and a Linear of the Logistics											
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Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tra		21. Signature of Funeral Service Licensee	. Funeral	Funeral Home, P.A.								
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F N F S	Me	29b. Signature and title of certifier	-	29d. Date signed (Month, Day, Year)								
		my m, m		009								
	2	30. Name and address of person who completed cause of death (II Ling Li, MD Assistant Medical Examiner 1	n Street, Baltimore	MD 21201								
		Ling Li, MD Assistant Medical Examiner 1 31. Date filed (Month, Day, Year) 32. Registrar's Sign		Jucet, Dalumore	5, IVIU Z IZU I							

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 0835 M Egger 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of maryland 57c ballimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1953 Australia Director 27, 212-64-6449 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show rel", or items 23a or 28a-f shov 1 ☐ Yes 2 X No **Funeral Director** Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 16 Pavilion Drive 20878 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2XNo Specify þ Specify. 3 Widowed 4 Divorced White Completed other traumetic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Govt. tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Central Intelligence Agency Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if Heelth and Mental William Elmer Eggert Patricia Margaret Eggert 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21701 9423 Saddlebrook Court, Frederick, Maryland Roy T. Eggert, brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Depertment of H Importent: If Ite eny Injury or ot 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 5 Other (Specify) 4 Donation Metropolitan Crematory 10/24/2009 Alexandria, Virginia 21. Signature of Faneral Ser ice Ccensee 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. P. ... Enter the disease, or complications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme te Cause disease and resulting in leah) Final evebral Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospitel or Attending Physicien: The law requires that the death certificete be executed for use as the burial-tran Due to (or as a consequence of). Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □ Yes 2 🖃 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury 27. Manner of Death 28d. Describe how injury occurred After t 28b. Time of 28c. Injury at Work? Injury To the Hospitel or Augmentage within 24 hours after death.

To the Funeral Director: Aft 1 Natural 5 Pending 19/09 motorcycle crash 1 ☐ Yes 2 ☑ No 2 Accident investigation 500 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Frederick 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10/16/09

Registrar
DHMH 17 Rev 1/2001

State

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WIRES

31. Date filed (Month, Day, Year)

of manyland

22 S. Greene St Baltimore

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** 21:01 P M Faulkner Alliston 15, 2009 /Medical <u>October</u> 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda

If Under 1 Year | If Under 24 Hrs. Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 ☑ M 2 □ F 578-52-6761 77 Director <u>May 11, 1932 Maryland</u> Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f sho event, it a Medical Evaning must be notified at 1**X**Yes 2 ☐ No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20814 United States <u>4521 East-West Highway #1502</u> death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc.African filed within 72 hours after 1 ∏Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: δ Specify: American 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amy Injury or other traumatic event, tra Many Injury or other traumatic event, tra Mangonee. Maintenance Engineer Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Susie Neale Vincy Faulkner 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Faulkner - Daughter 5602 Livingston Terr. #302 Oxon Hill, MD 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State Maryland Nat'l Mem. Park Oct 24, 2009 Laurel, MD 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the dise 🚎 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, which eart failure. List only one cause on each line. Approximate Interval Between Onset and Death UNKNOWN Immediate Cause (Final disease or condition resulting in death) Intertitial Lung Disease **Physician** /Medical Due to (or as a consequence of): Examiner Acute Renal Failure Unknown Sequentially list conditions, if any, record go manufacture cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off-Exami Diabetes Mellitus Unknown attending physiclan and for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 X No 1 ☐ Yes 2 X No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊠ No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending P n 24 hours after death, ne Funeral Director: After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the a within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062999 October 16, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Petek Donmez, M.D. 8600 Old Georgetown Rd. Bethesda, MD 20814 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 1 2009 Registrar

DHMH 17 Rev 1/2001

October 15, 200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 18, 2009 **Physician** 7:00 A Annabelle Horner Glascock /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert Solomons 325 Strathmore Lane If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, Months Days Hours 1 □ M 2 🛛 F March 30, 1933 Maryland 214-30-9572 76 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b County 1 ☐ Yes 2 No Director Maryland Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20688 United States 325 Strathmore Lane by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🎇 No If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luther Horner Ruth Northan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bedford Glascock / Husband 325 Strathmore Lane, Solomons, Maryland 20688 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Middleham Chapel Cemetery 10/23/2009 | Lusby, Maryland 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. Signature of Funeral Service Licensi michael Kever P.O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final years. canc disease or condition resulting in death) ung Due to (or as a * nsequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760. physician attending p signed by the a P.O. Division of Vital Records, certificate After this al or Attending P s after death.
Il Director: After ed in by the funer within 24 hours a To the Funeral D Hospital

Funeral

Director

28a-f show

ed other than "natural", or Items 23a or 28a-f shovevent, the Medical Examiner must be notified at

3altimore, Maryland 21215-0036

within 72

12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau

Physician

/Medical

Examiner

the burial-transi

as

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Pages 1

28W 6

State Registrar 29a. Certifier

(Check only

29b. Signature and title of certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pate

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

32. Registra s Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mary Elvira Gibbons October 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days 1 □ M 2 🖾 F 178-16-4221 89 <u>07/30/1920</u> Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1448 Potomac Avenue 21742 US 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2X Married If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) $\overset{\text{Elementary/Secondary (0-12)}}{12}$ College (1-4or 5+) Secretary Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Ermine Conner Ruth Elizabeth Boward 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald C. Gibbons 1448 Potomac Avenue, Hagerstown, MD 21742

Rest Haven Cemetery 10/24/2009

20c. Location - City or Town, State

Hagerstown, MD

21740

Date

ROAD HARRISTOWN MD

22. Name and Address of Facility Gerald N. Minnich Funeral Home

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, In. M. dical Expirity and the nutitied at once.

20a. Method of Disposition

1X Burial 2 ☐ Cremation 3 ☐ Removal from State

&MIR

OCT 23

GHAZAUS

31. Date filed (Month, Day, Year)

1190

32. Registrar's Signature

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

1 - For State Registrar

10a. State

MD

Director

Funeral

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Completed

Be

Physician

/Medical

Examiner

Funeral

Director

show

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

burial-tran ed by the sign Pe

law requires that the death certificate be executed To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this cartificate to s after dec. completely

Division of Vital Records, P.O. Box 68760,

an ted		305 1	N. Potomac St	reet, Hager	stown, I	MD 21740			
23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	YFORAT	t enter the mode of dying, such as cardiac or respiratory arrest,						
Sequentially list conditions, if any, seaming to firm collections. Enter Underlying Cause, (Disease or Injury that initiated events resulting in death) Last	b. CAECAL CAECACACA CAECAL CAECAL CAECAL CAECAL CAECAL CAECAL CAECAL CAECAL CAECAL CAECAL CAECAL CAECAL CAECAL CAECAL CAECAL CAECAL CAECAL CAE	MONTHS							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d. Date of delivery Month Day Yea							
Part II. Other significant conditions of	ontributing to death but not resulting	in the underlying	cause given in Part I.		o use contribute t	to the cause of death? Probably 4 Unknown			
				24a. Was an autopsy performed? 1 □ Yes 2 ☑	prior to death?				
25. Was case referred to medical examiner?	111a-1								
1 Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/C		OOA Other: 4 I Nursing I	Home 5 Residence	6 ☐ Other (Spi	ecify)			
27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	(Month, Ďay, Year)	Time of Injury M	28c. Injury at Work? 1 □Yes 2 □No	28d. Describe how inj					
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	farm, street, facto	ry, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowledgetiner: On the basis of examination a and manner stated.	ge, death occurre and/or investigation	nd at the time, date and place on, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner a nd place, and du	as stated. e to the cause(s)			
29b. Signature and title of certifier		2	9c. License number	29d. D	29d. Date signed (Month, Day, Year)				
* Moedu	1 MD		D46561	ct 20	, 2009.				
30 Name and address of person who	positional course of death (Itam Con)	(Time Drint)							

20b. Place of Disposition (Name of cemetery, crematory or other place)

DHMH 17 Rev 1/2001

State

Registrar

MT AEMA

State Registrar

3

3

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

of Vital Records,

Division

DHMH 17 Rev 1/2001

9801

\$2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shyamsundar Rajan, MD

21 2009

31. Date filed (Month, Day, Year)

D53367

10/19/09

Georgia Ave. Suite 117 Silver Spring, MD

20902

Months

ANNAPOLIS

Hours

Days

MCKAY HUTCHINGS

1 □ M 2 🗷 F

7. Age (In yrs. last birthday)

Vrs

89

1. Decedent's Name (First, Middle, Last)

Social Security Numbe

216-16-1392

4a. Facility Name (If not institution, give street and number)

GINGER COVE HEALTH CENTER

Physician

/Medical

Examiner

Funeral

Director

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 2. Date of Death Month 0530 R.M 0 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL 8. Date of Birth (Month, Day, Year)

NOVEMBER 25,1919 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) MARYLAND 10d. Inside City Limits 1 ☐Yes 2 No 10g. Citizen of What Country? UNITED STATES 14. Race - American Indian, Black, White, etc. Specify: WHITE 16b. Kind of Business/Industry ANNE ARUNDEL COUNTY PUBLIC SCHOOLS 18. Mother's Name (First, Middle, Maiden Surname) CECELIA MILLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 470 CRANES ROOST COURT, ANNAPOLIS, MARYLAND 21409 20c. Location - City or Town, State Date **OCTOBER** 2009 STEVENSVILLE, MARYLAND

22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 21401 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 3 No 1 ☐ Yes 26. Place of Death (Check only one) GINGE COVE Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DA

State Registrar (Check only one)

31. Date filed (Month, Day,

29b. Signature and title of certifier

Name and address of person who

1

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32

back

4

ed cause of death (Item 23a) (Type, Print);

With Ith

Registrar's Signature

29c. License number

EFENSE HIGHWAY ANNAPOLY MOZIYU,

09-08053 Barry Harbison

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

arry Harbison			ficate of Death	Reg. No. 2003 353								
Physicia Medical Examin	in/	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year October 16, 2009 3. Time of Death 1710 hrs								
neulcai Exami	ilei	Barry Byron Harbison 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death									
		Calvert Memorial Hospital	Prince Frederick	Calvert								
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 374-74-2217 1XM 2F 49	t birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	The section								
ow any	ł	Calmont	own or Location	10d, Inside City Limits 1 X Yes 2 No								
te Maryland or 28a-f show fied at once	Director	MD Carvert 10e. Street and Number	Dunkirk 10f. Zip Code	10g. Citizen of What Country?								
th the Ma 23a or 28		9914 Mc Intosh Drive	20754	USA specify Yes or No- 14. Race - American Indian, Black,								
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.) White, etc.								
urs afte	ğ	3 Widowed 4 Divorced If Yes, Give Year or Datas: 15. Decedent's Education (Specify only highest grade completed) 1	1 Yes 2 X No specify:									
5-0036 Tied within 72 hours Hygiene. d other than "natuu	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ret	Naval Research								
15-003 filed within Hygiene. d other tha	g mo	17. Father's Name (First, Middle, Last)	Engineer 18 Mother's Nam	Laboratory le (First, Middle, Maiden Surname)								
ked nt.	BeC	Byron Harbison		e Grondin								
re, MD 2121 stand 2 should be fil f Health and Mental F f fitem 27 is marked er traumatic event, I		19a. Informant's Name/Relationship (Type, Print)	,	Rural Route Number, City or Town, State, Zip Code)								
ore, MD ss 1 and 2 sho of Health and If item 27 is		Michelle Harbison/Wife 20a. Method of Disposition 20b. Pia	ace of Disposition (Name of cemetery,	Date 200. Location - City or Town, State								
Baltimore, Mermit. Pages I and Department of Health Important: If item injury or other trau	П	1 Burial 2 X Cremation 3 Removal from State	ematory or other place)	/22/09 Beltsville, MD								
Baltimore permit. Pages 1 Department of 1 Important: If injury or other		4 Donation 5 Other Specify: C116 21. Signature of Funeral Service Licensee	Siry.									
Balt permit. Departi Import injury	0.0	5. Wood	PO Box 430, Dunkirk, MD 20754									
Physician /Medical		failure. List only one cause on each line.	art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line.									
caminer		Immediate Cause (Final disease or condition resulting in death) a. Peritonitis Due to (or as a consequence of):		Death								
		Sequentially list conditions, b. Perforation of Diverticulu	m of Colon									
	ine	if any, leading to immediate cause. Either Unioening Cause C. Due to (or as a consequence of):										
sit sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		d. UNPENDED AMENDED										
60, ate be	Medical	IF FEMALE: 23c. If yes, outcome of pregna	ancy	23d. Date of delivery								
687 certific nding p	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time of deal	2 Fetal death 3 Ectopic pregr	nancy Month Day Year								
Box death death death	Physician/	1 Yes 2 No 9 Unknown g Unknown	tn 5 Other (Specify)									
P.O. B res that the d signed by the be detached	by P	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown								
S, P				24a. Was an 24b. Were autopsy findings available								
cords, law requir	Completed			autopsy prior to completion of cause of performed?								
cal Rec		25. Was case referred to medical	26.Place of Death (Checl	1 Yes 2 No 1 Yes 2 No								
Vital ysician: his certif director,	o Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V E	Othor	sing Home 5 Residence 6 Other:								
ing Phy		27. Manner of Death 28a. Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred								
ivision or Attendi after death. Director:	atio	Natural 5 Pending 2 Accident Investigation	1 Yes 2 No									
Divis	Certification:	Suicide Could not be	me, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
D To the Hospital within 24 hours To the Funeral completely filled		4 Homicide (Specify) 2ga. Certifier (Cheek only 1 Certifying Physician: To the best of my knowledge	e, death occurred at the time, date and place, ar	nd due to the cause(s) and manner as stated.								
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner:On the basis of examination and manner stated.	d/or investigation, in my opinion, death occurred	d at the time, date and place, and due to the cause(s)								
F S F S	ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)								
		N-MU-M	O.C.M.E.	October 17, 2009								
dry 10		30. Name and address of person who completed cause of death (Item 2 Donna M. Vincenti, MD Assistant Medical Exam		MD 21201								
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	e ,									
Regist		OCT 2.0 2009 Seners	8. Janes									

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Lucy Alice Howell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Alleggny WMHS- Memorially (In yrs. last birthday) 8. Date of Birth (Month, Day, Aug. 17 Birthplace (State or Foreign Country) Age 95 **Funeral** 1 □ M 2**X** F Months Min Maryland Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show Examiner must be notified at MD. Allegany Barton Director 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24 any injury or other traumatic event, the Medical Examples once. PO Box 91 Dogwood Flat Lane 21521 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ANo Specify: ρ Specify: 3℃Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Service Station Elementary/Secondary (0-12) College (1-4or 5+) Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonard Ella Mae Shimer Moore ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14409 North BelAir Drive, Cumberland, Maryland 21502 Betty Howell/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 10/30/ 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Barton Maryland Mt. View Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St. Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that cause of the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying su, as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician the burial Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unkn 9 Unknown ase given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? nas 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 1∐Yes 2XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending iours after death.

Peral Director; Ai
filled in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled i 29a. Certifier 1 Certifyl Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only Medical aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

30. Name and address of person w

31. Date filed (Month, Day, Year)

Dr. Juan Arristeno,

2 8 ZUUS

o completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c License number

902 Seton Drive, Cumberland, Maryland 21502

29d. Date sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For	State of Maryland /	Department of H	Health and M	fental Hygie	ene ooo	0.500
		1 - State Registrar		Certificate of	Death		.No. 2009	0002
Physicia	an	1. Decedent's Name (First, Middle, Last)	1 0000	11-11-1		2. Date of Death Month	Day Year	3. Time of Death 9:00 P M
/Medic		4a. Facility Name (If not institution, give s	treet and number)	4b. City. Town. o	or Vocation of Death	Oc tober	13 2009 4c. County of Death	9.00 P M
Examin	ier	113 Mitchell	Street Apt. 2.	C 5+1	Michae	15	Talbot	-
Funeral Director		5. Social Security Number 6. Sex 216-14-9460	7. Age (In yrs. last b	yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y May 10, 1	9. Birtho	place (State or Foreign atry)
and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location		, ,	1	0d. Inside City Limits
Maryla	tor	MD Talbox		t. Michael	<u> </u>			1 es 2 No
1 28 th	Director	10e. Street and Number	91	10f. Zip Code	S	10g	j. Citizen of What Cour	ntry?
23a c	ralD	113 Mitchell	St. Apt. 2-C	216	63		USA	
er dez Items	Funeral	11. Wantar Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp ean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
urs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1	1 ☐ Yes 2 1 No	Specify:		Specify: R 1	2CK
be filed within 72 hours after death with the Maryland to theygiene. The Hygiene do ther than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		a. Decedent's Usual Occup (Give kind of work done	pation during most of work	ina 16	6b. Kind of Business/In	
vithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire	d) "		C -C	1
be filed v tal Hygie d other t event, th		17. Father's Name (First, Middle, Last)	Pr	ocessing L	18. Mother's Name	KEY e (First, Middle, Ma	iden Surname)	<u>a</u>
id be lental rked o	To Be	Arvery F	ields		Mildr	pd 11/p.	115	
ione, Invarylating ZIZIS-0030 ges 1 and 2 should be filed within 72 hours after death with the Marylar for Health and Mental Hygiene. If of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Mental Examiner must be notified at	-	19a. Informant's Name/Relationship (Typ		b. Mailing Address (Street			City or Town, State, Zip	Code)
C, N 1 and 2 Health em 27 l	3	Faith Hol	liday 1	43-Brock1		redeva		10,21632
ages 1 at of H or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	of Disposition (Name of tery, crematory or other pla	ce)		oc. Location - City or To	
Dallullion permit. Pages Department of Important: if it any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Chas.	thomas Come 22. Name and Addre			3t. Micha	els, MV,
permit. Departr Importa any inji		Janelle	C. Henry	Henry Fu	Shinaton	1 St. Cal	ubridge, N	1D.21613
		23a. Part1 Enter the disease, or complication shock or heart failure. List only on	cations that caused the death. Do	not enter the mode of dyi	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death))	rhosis			104cm3
Examiner			Due to (or as a consequence	ë of):				
	ner	Sequentially list conditions, if any leading to immediate	Due to (or as a consequence	e of):				
ecutec ind transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
of ou, cate be executed bhysician and the burial-transit	al E	resulting in death, East	Due to (or as a consequence	e of):				
ficate p physis the	edical	d						
h certi	M/u	ZSD. was decedent pregnant	3c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea	th 3□Ectopic pregnanc	2		23d. Date of delive	,
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending picompletely filled in by the funeral director, page 2 should be detached for use as a	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐Unknown	5 ☐ Other (specify) _			Month	Day Year
that the detac		Part II. Other significant conditions con	stributing to death but not resulting	in the underlying cause giv	ven in Part i.	23e. Did toba	cco use contribute to t	he cause of death?
law requires as been sign	Completed by	Anemia, Ren	al Insufficie	ney Lup	45	1 ☐ Yes	2 No 3 Prol	bably 4 □Unknown
law re	plete					24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
The take his page	Com	come syman come				performe	ed? death?	2 □ No
VICAL Ician: 1 certificat ector, pa	Be	25. Was case referred to medical examiner?	lospital:	Lou	nor:	th (Check only one)		
Phys er this eral dii	10	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury 28b	Time of 28c. Inju	4 Li Nursing Fig	ome 5 Residen 28d. Describe how	ce 6 Other (Special of Injury occurred	<u>'y)</u>
ath. rr: Afte	atior	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)		rk?]Yes 2 ☐ No			
To the Hospital or Attending Physician: The Hospital or Attending Physician: The Funeral Director: After this certification of the Funeral Director: Completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, building, etc. (Specify)	farm, street, factory, office		28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
spital ours a neral C		29a. Certifier Certifying Phys	sician: To the best of my knowled	ge, death occurred at the t	ime, date and place,	and due to the cau	use(s) and manner as s	stated.
the Ho in 24 h the Fu	edical	(Check only 2 Medical Examir	ner: On the basis of examination a and manner stated.	and/or investigation, in my	opinion, death occur	rred at the time, dat	te and place, and due t	o the cause(s)
To t To t	Σ	29b. Signature and title of confier	1 L M	29c. Licens			d. Date signed (Month,	Day, Year)
2		30 Name and address of	mploted cause of death (Item 22) (Typo Print)	47492	_	Oct. 21,	2009
J		30. Name and address of person who co	mpleted cause of death (Item 23a	5 Cynward	Dr, E	aston 1	ms 2/	601
Sta Registr		31. Date filed (Month, Day, Year) OCT & 1	32. Registrar's Signature) (Type, Print) 5 Cyn ward 1. parks	_/	7		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death Пау Month

Physician /Medical Examiner

3altimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

law requires that the death certificate be executed burial-transi and the attending physician the for use as detached cate nas been signed by : page 2 should be detach Physician: The certificate funeral director, this Hospital or Attending Pi 24 hours after death. Funeral Director: After t After the filled in by within 24 hours a To the Funeral C completely

1 - For State Registrar Decedent's Name (First, Middle, Last) Physician Isidore NMI Horowitz 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Min 1**∑**M 2□ F 89 Director 080-14-5356 1919 New York Dec. 7, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I'm Medical Examinar must be rotified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 No Director MD Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10152 Garis Shop Road 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∭Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2X No Specify: Completed by 3 ₩ Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Aircraft College (1-4or 5+) Elementary/Secondary (0-12) Flight Mechanic Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Horowitz Sadie (Unknown) Horowitz ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deidre L. Cooper/Daughter 758 Carl Ci. P.O.Box 145, State Line, PA 17263 permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 10/24/2009 Rest Haven Cemetery Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee S. Mull Si 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw immediate Cause (Final disease or condition resulting in death) Due to La as a consequence if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 \square No 1 □ Yes 2 (L) No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2/1 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manual of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident 1 □Yes 2 □ No Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier. 29c. License number 29d. Date signed (Month, Day, Year) MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21742

Year

5H5+1 State

31. Date filed (Month, Day, Year)

SHAHAD

32. Registrar's Signature

ORIGINAL

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	S	State of M	arylar						ental Hy	giene	0.0			
			Registrar	(المحمد المالية			Ce	rtitica	ite of i	Death			Reg. No.	200	19	35	533(
П	Physici	ian	1. Decedent's Name (First, M		-							2. Date of De Month	Day			3. 1 me t	it Death M
-	/Medi		Aubrey W. 4a. Facility Name (If not instit				-	4h Cit	y Town o	r Location o		Octobe:		2009 County of D		9:01	_ A
3	Examir	ner	Washington A						oma I		or Boatti			ontgon			
	Funeral		5. Social Security Number	6. Sex	7. Ag		last birthday)	If Und	er 1 Year	If Under	24 Hrs.	8. Date of Bir (Month, Da					or Foreign
	Director		223-46-4953	1 K M	1 2□ F	73	Yrs.	Month	s Days	Hours	Min.	March	1,193	3/	_	n land	
	pu »		Usual Residence of Deceden 10a. State 10b. Col			100 Ci	ty, Town or Lo	action								d. Inside (City Limito
	laryla sho	ō	MD Calv				ntingto										s 2 No
	the N	rect	10e. Street and Number	EIL		Hui	ILLIIGLO		Ip Code				10a Citi	zen of What	Count		
	3a or	Ö	2600 Hidden H	ill Co	urt				0639				U.S.			,.	
	ms 2	nera	11. Marital Status		Was Decedent	Ever in U	.S. 13.			lispanic Ori	igin? (Spe	cify Yes or No Rican, etc.)		14. Race - A			
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventual near near the neithflood and once.	by Funeral Director	1 ☐ Never Married 2 🛣		Armed Forces? 1 Yes 2 ☐ If Yes, Give Year or Dates:	No 1955			ecity Cuba 2 No	an, Mexicar Specify:		Hican, etc.)		Black, W Specify: V	_		
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and	be fill ad oth even	Be	17. Father's Name (First, Mid		C.							(First, Middle,		Surname)			
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, Maryland	alth an 27 is a		Debra Johns	1 ()1	,							Huntin;					
Jre,	of He		20a. Method of Disposition			20b. I	Place of Dispo cemetery, crer	sition (N	ame of other plac	ce)	D	ate	20c. Lo	cation - City	or Tov	n, State	
<u><u>Ë</u></u>	Page ment ant: It ury o		1 Burial 2 □ Cremati 4 □ Donation 5 □ Othe		loval from State		Vetera				10-23	-2009	Che	Ltenha	am,	MD	
Baltimore,	permit. Depart Import any Inj		21. Signature of Euneral Sen	rice-Licensee								sch Fu					
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-	/Medical Examiner		resulting in death)	(a	Due to (or as	a conse	uence of):										
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Вох	eath certifi attending for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c.	If yes, outcome 1 ☐ Live birth			Ectopic	pregnanc	v			2	3d. Date of		-	
0	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4 ☐ Pregnant a 9 ☐ Unknown			Other (<u> </u>				Month	ı	Day	Year
σ.	that the dened by the a		Part II. Other significant con	ditions contrib	outing to death b	ut not res	ulting in the u	nderlying	cause give	en in Part I.		23e. Did to	obacco u	se contribut	e to the	cause of	death?
Records,	uires n sign ld be	d by										1 🗆 🕆	/es 2[]No 3[] Proba	bly 4	Unknown
Ö	w requir s been s should	Completed										24a, Was	an	24b, Wer	autop	sv findinas	available
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Vital	sician: The certificate rector, pagi	BeC	25. Was case referred to med	lical						26. Place	of Death	1 □Yes (Check only o	ne)	1 1 1	res :	2 LINO	
†	nysic is ce direc		examiner? 1 Yes 2 □ No	Hos	pital; 1 ☐ Inpati	ent 2	ER/Outpatier	nt 3	OOA Oth	er: 4 🗆 Nu	ursing Hon	ne 5 Resid	dence 6	Other (Specify)	
n of	ding Ph h. After th funeral	ü	27. Manner of Beath Natural 5 ☐ Per		28a. Date of Inju (Month, Da	ıry ıy, Year)	28b. Time of Injury	f	28c. Injur Worl	y at k?	2	8d. Describe I	now injury	occurred			
Sio	Attending Physician: or death. ector: After this certific by the funeral director, I	cati	2 ☐ Accident inv	estigation				M		Yes 2 🗆							
Division	or At after o Direct in by	Certification: To		ermined	28e. Place of Inj building, et	ury - At h	ome, farm, str <i>fy)</i>	eet, facto	ry, office		2	8f. Location (8) City or Tov	Street and vn, State)	d Number o	r Rural	Route Nui	nber,
	To the Hospital or Attent within 24 hours after deatt To the Funeral Director: completely filled in by the		(Check only 2 Med	fying Physici cal Examiner	an: To the best On the basis of	of examina	owledge, death	h occurre	ed at the tir	me, date ar	nd place, a	and due to the	cause(s)	and manne	r as st	ated.	(s)
	thin 2 the 1 the 1	Medical	one) 29b. Signature and title of cer		and manner st	ated.		7	9c. Licens					e signed (M			
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			30. Name and address of pen	son who comp	leted cause of	leath (Iter	n 23an (Tyne				•		1-1	-	- /		
dru) 6+ 1			CULAST	2	cus.	/	R	11	7600 (Carro	11 Ave	. Tak	coma F	ark	,MD 2	20912
	Sta		31. Date filed (Month, Day, Ye		32. Registr	, -	-5	1	. 0 6								
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death A 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 25, 2009 **Physician** Elmer Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frostburg Allegany Frostburg Village Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours 10XM 2□ F Maryland August 01, 1915 Director 214-07-3672 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County other traumatic event, the Madical Evaminary ust be notified at Yes 2 □ No Funeral Director Frostburg Allegany Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **USA** 21532 One Kaylor Circle 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by Specify. 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Trucking 0 Driver 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Mae Ternent John Johnson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) t. Pages 1 and. 425 Braddock Street, LaVale, Maryland, 21502 Linda Miller - Daughter Department of Healt Important: If item 2 any Injury or other once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date October 28 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Moscow Mills, Maryland Laurel Hill Cemetery 2009 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** ORON AVY disease or condition resulting in death) m /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innertal director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year 5 Other (specify) ∃Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 → Seknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 Inpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registral 's Signature State 29 Registrar

DHMH 17 Rev 1/2001

Box 68760.

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 22, 2009 Robert Leroy Knox October 1:05 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 409 Maple Avenue Loch Lynn Garrett If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1X M 2□ F 220-38-0625 68 Maryland Director April 17 1941 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No Director MD Garrett Loch Lynn death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 409 Maple Avenue 21550 United States Funeral Race - American Indian. Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Pepperidge Farms 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Harvey Knox Mary Margaret Stephen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Julia Knox, Wife 409 Maple Avenue, Loch Lynn, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 10/27/2009 20c. Location - City or Town, State Department of I Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Valley Cemetery Oakland, MD 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550 21. Signature of Funeral Service Licenses Katherise 23a. Part1. Enter the disease, or complications that Caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** foo! Stage 3 mo disease or condition resulting in death) /Medical line anoep Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed as the burtal-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown aneurism 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2 autopsy 1∐ Yes 2🛛 No or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 5 Residence 6 □Other (Specify) 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation (Month, Day Year) Injury Natural 2 Accident ours after death. neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

To the Hospital

State Registrar

29d. Date signed (Month, Day, Year)

29c. License number 29b. Signature and title of certifier

of person who completed cause of death (Item 23a) (Type, Print)

MO

32. Registrar's Signature

27 2009 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10/16/2009 Day **Physician** 9:15 P Jay G. Kleinfelter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester | Months | Days | Hours | Min. | Min. | Months | Days | Hours | Min. | Min. | O4/15/1947 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 6. Sex 1 X M 2 ☐ F PA 62 Yrs Director 165-38-0361 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show items 23a or 28a-f shore 1X Yes 2 No **Funeral Director** MD Ocean City Worcester with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death \(\) Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a any hijury or other traumatic event, the Madical Expriner right once. 21842 USA #4 84th St.Unit 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify. If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education System School teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be H. Russell Kleinfelter Genevieve Yasko မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #4 84th St. Unit 31 Ocean City MD 21842 Diane Kleinfelter (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/19/2009 Frankford DE 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St Berlin, MD 21811 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner mores Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 1 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 21√1√0 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation (Month, Day, Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

BA 25

State Registrar

Year) 31. Date filed (Month, Day,

29b. Signature and title of certifier

(Check only one)

32. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20 2009

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

feathway prive

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** RICHARD CLAYTON KELLOGG Oct. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 7829 Dividing Creek Road Pocomoke City Somerset | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Dec. 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) 1 **J**M 2 □ F 163-32-8821 70 1938 Penn Director Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ed other than "natural", or items 23a or 28a-f shov event, the medical Experience must be notified at 1 ☐ Yes 2 ☐ No MD Somerset Pocomoke City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7829 Dividing Creek RoaD 21851 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 ☐No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) marked other than College (1-4or 5+) Truck Driver Transportation 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be 1 lealth and Mental Clayton Laverne Kellogg Joyce Ann Kistner other traumatic ည Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Virginia Kellogg/ Wife 7829 Dividing Creek Rd., Pocomoke, MD 21851 Health a Item 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 Important: If It any injury or o 1 ☐ Burial 2☐ Fremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 10/20/2009 Salisbury, MD 21804 21. Signature of Fungal Service License 22. Name and Address of Facility Micha Holloway Funeral Home, P.A., 107 Vine Street, Poodmoke, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Immediate Cause (Final Yulmow **Physician** ARONIC /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed the burial-trans and Due to (or as a consequence of) Box 68760. physician Physician/Medical as attending IE FEMALE nse ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) P.O. I the a ☐Yes 2 ☐No 9 Unknown 9 Unknown ò signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐Yes 2 ☐ No 1 □Yes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After (Month, Day, Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

E.J State

31. Date filed (Month, Day, Year)

YAUL FLEURYMO

29b. Signature and title of certifie

Registrar's Signature **DCT 2 0 2009**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

305

Registrar

29c. License number

024872

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 06:13M Medical 4a. Facility Name (if no vinstitution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Clintor land Hospital southern If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Social Security Number 6. Sex 1 **X** M 2 □ F L Yrs. Director 222-30-2347 Usual Residence of Decedent 10a. State 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Prince George's Clinton MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20735 9106 Pineview Lane **NZA** ral", or items a 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced White Year or Dates 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Construction and Mental Hygier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Henry Kupis Minnie Marcum f Health an. m 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Paladinetti, Sister 2105 Barr Rd., Wilmington, DE Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 10-22-09 Beltsville, MD Chesapeake 21. Signature of Funeral Service Lice 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd - Camp Springs MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi neumonia Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Month Year Day Pregnant at time of death signed by the a Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy death? 1 Yes Yes 2 No To Be 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA After this 27. Manner Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No after death. Director: Aft 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours aff

To the Funeral Di

completed filled in Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title 29d. Date signed,(Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 2 1 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Paula Joan Lee 2 ð ð 9 9:42 ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring 713 Downs Drive Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F 0870277938 Vashington. Director 578-50-9371 Usual Residence of Decedent "natural", or items 23a or 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 713 Downs Drive 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced White. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Fetsko Catherine Glubshinsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 713 Downs Drive, Silver Spring, Maryland 20904 Lawrence Lee - Husband Baltimore, 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cem. 10/21/2009 | Silver Spring, MD Signature of Funeral Service to censée 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 100769 11800 New Hampshire Ave.. Silver Spring. MD20904 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Day Year 4 ∐ Pregnant a 9 ☐ Unknown 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy Yes 2 X 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 X No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural iniury 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 0060036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) amberton Dr. > Silver Spring, MD

Registrar

State

ahwoud

31. Date filed (Month, Day, Year)

OCT 21

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			Pleas	e Type or Prin State of Ma						•		egibl	le.	
			1 - State Registrar			Cei	rtificate o	f Death			g. No. 2	201	19	35337
	Physicia /Medic			MARGARET L	AWRY					Date of Death Month 10 - 2	т —	200		3:45 P M
	Examin	er	4a. Facility Name (If not institution, in GARRETT COUNTY	,	CDTTAI			, or Location of LAND	f Death			ounty of GARR		
	Funeral			Sex 7. Age	e (In yrs. last bir	rthday)	If Under 1 Yea	ır If Under 2	24 Hrs. 8.	Date of Birth (Month, Day,				ace (State or Foreign
	Director		234-26-0675 Usual Residence of Decedent	1□M 2\ F	89	Yrs.	Months Day	s Hours	Min. 0 2-	-14-192	20		PA	
	hours after death with the Maryland turel", or items 23e or 28a-f show at Evantime inst be motified at	_	10a. State 10b. County		10c. City, Tow	n or Lo	cation						10	0d. Inside City Limits 1X Yes 2 □ No
	be filed within 72 hours after death with the Marylan ital Hygiene. d other than "naturel", or items 23e or 28a-f show event, Ital Madical Evantimer oust be motified at	Director	WV MARI 10e. Street and Number	ON	FAIRM	ONT	10f. Zip Code			10	g. Citize	n of Wh	at Count	
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	death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S.	13.	Was Decedent of f Yes, specify Co		gin? (Specify	Yes or No-	14	. Race -	America	an Indian,
36	or ite	by Fu	1 ▼ Never Married 2 Marrie	d 1 □Yes 2 🕅 N If Yes, Give	lo		1 □Yes 2 X N		, ruello nice	ari, e.c.,	s	pecify:	White, e	
Ö	hours turel"	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:	16a	Dece	dent's Usual Occ	cupation		1	6b. Kind			HITE
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2	filed within 'Hygiene.'	Completed	Elementary/Secondary (0-12)	2	*/		CREDIT	MANAGE					T SI	JPPLY
änd	wild be file Mental H erked oth atic even	Be	17. Father's Name (First, Middle, La	·						rst, Middle, Mi	aiden Si	ırname)		
Maryland 21215-0036	should be and Menta s merked umatic ev	ပ္	DANIEL LEWIS L 19a. Informant's Name/Relationship		101	Mailir	ng Address (Stre		ORA SC		City or 7	Town St	ato Zin	Codel
	as 1 and 2 should b of Health and Ment I tem 27 Is merked r other traumatic e		LaDonna Bosse,				Turnpik				•	,	279	0000)
ore,	of Hear		20a. Method of Disposition 1 □ Burial 2 X Cremation 3				sition (Name of natory or other p		Date					wn, State
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Baltimore,	permit. Pages 1 Department of the Important: If ite any Injury or of once.		21. Signature of Funeral Service Lie	censee			2. Name and Add		riey	Home f				
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	Physician		shock, or heart failure. List or Immediate Cause (Final	nly one cause on each lin	ie.	40.0	- 10: 4	29111g, 30011 d3	cardiac or re	spiratory arro	31,			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequence	of):	Jusin	L					+	year
	Examiner	_	Sequentially list conditions,	b										
	rted nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consequence	of):								
o,	be executed sician and burial-transit	Exal	that initiated events resulting in death) Last	C	a consequence	of):								
3760	ate be hysicia the bu	lical		d										
x 68	death certificate t e attending physic d for use as the b	Physician/Medic	IF FEMALE:	23c. If yes, outcome	of prognancy								i	
Box	atten for u	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death		Ectopic pregna				23	d. Date Mont	of delive h	Day Year
<u>Ч</u>	t the c by the tachec	hysi	9 Unknown	9 Unknown										
Records, I	iclan: The law requires that the decertificate has been signed by the rector, page 2 should be detached	by	Part II. Other significant condition	s contributing to death bu	ut not resulting i	n the u	nderlying cause	given in Part I.		23e. Did toba			ute to th	e cause of death?
ဝ၁	aw rec	plete								24a. Was an		24b. We	ere auto	psy findings available
	The late he	Completed								autopsy perform 1 Tes 2	ed?	de	or to cor ath? ∃Yes	mpletion of cause of 2 □ No
Vital	iding Physician: th. After this certifics funeral director, f	Be	25. Was case referred to medical examiner?	Hospital:			10	Thor:		heck only one				
	Phys er this eral dii	: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injur	ry 28b.	utpatier Time o	IL 3 LI DOA	njury at		5 Resider Describe hove			· · · ·	y)
<u>o</u>	Attending Physician: or death. ector: After this certific by the funeral director,	atio	1 Natural 5 Pending 2 Accident investiga	(Month, Day	v, Year)	Injury	l v	√orḱ? ∐Yes 2∐1	No					
Division of	of or Attend efter death Director: A	Certification: To	3 Suicide 6 Could no 4 Homicide determin		ry - At home, fa : (Specify)	arm, str	eet, factory, offic	e	28f.	Location (Street) City or Town,		Number	or Rura	l Route Number,
	To the Hospitel or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier Certifying (Check only one) Medical Ex	Physician: To the best of xaminer: On the basis of and manner sta	f examination a	e, deat	h occurred at the vestigation, in m	e time, date an ny opinion, dea	nd place, and th occurred	I due to the ca at the time, da	use(s) a te and p	ind man	ner as s	tated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	/ /			29c. Lice	ense number	_	29	d. Date	signed (Month,	Day, Year)
			Margaret a	Hain	w		1	2665	Ó		10 -	27-	20	99
			30. Name and addless of person w	1 .	eath (Item 23a)	(Type,	Print) morial	70	m	01-	0 1	11-	100	
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	Mei	morral.	LKIVE	U	ucrand	11/1	d -	45	
	Registr		OCT 28	2009	us B	A	parker							

Registrar DHMH 17 Rev 1/2001

	Registrar 1. Decedent's Nam	e (First, Middle,	Last)			tificate of	20001	2. Date of Dea	ith Day	Year	3. Time of Death
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ner	4a. Facility Name (mber)			r Location of Deat	h		ity of Death	
	Kline 5. Social Security N	Hospice	House 6. Sex	7. Age (In yrs. la	st hirthday)	Mt. A		8. Date of Birth		ederi	CK pplace (State or Foreign
	213-56-4		1 □ M 2 🗶 F	80	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day April 2:	, Year) 3, 1929	Cot	aly
	Usual Residence o	f Decedent									
7	10a. State Maryland	Montgo	ma r v		Town or Loc Silver	Spring					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
חוברוח	10e. Street and Nu		шегу			10f. Zip Code			10g. Citizen o	of What Cou	
5			eisure Wo	orld Bou	levard		5		USA		, ,
	11. Marital Status		12. Was Dece Armed Fo	edent Ever in U.S.	. 13. V	Vas Decedent of I	Hispanic Origin? (S an, Mexican, Puerl	Specify Yes or No-	14. R	ace - Amer	ican Indian,
by runeral		ried 2 Marrie		2 No		☐Yes 21xNo	Specify:	to ritidan, Ctc.)	Spec		hite
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Completed			grade completed)		(Give I	kind of work done OO NOT use retire	during most of wor d)	rking	TOD. KING OF	Dusiness/ii	ndustry
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í	17. Father's Name	(First, Middle, L	ast)					me (First, Middle,		ame)	
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	19a. Informant's N Vittoria		ip (Type. Print) - daugh :	ter	19b. Mailin 7098	g Address (Street Brownsto	and Number or Ri one Court	ural Route Numbe , Middle	r, City or Tow town,	n, State, Z Maryl	and 21769
	20a. Method of Dis		3 ☐ Removal from	20b. Pla	ace of Dispos metery, crem	sition (Name of natory or other pla	ce)	Date	20c. Location	-	
		5 Other (Spe		Fort	Linco	oln Cemet	- 1	J.			g, Maryland
	21. Signature of Fu	uneral Service	icensee	1		. Name and Addre		Stauffer			
	Mur	on Qu	anull				sumtown P			, Mar	
			omplications that c nly one cause on e	aused the death.	Do not ente	er the mode of dy	ng, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Immediate Cause disease or condition resulting in death)	on	-a	VER 7	FAILU	ire					DAYS-MONTH
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3	- ENDOC	ARD ITT	5					1□Y	es 2 No	3□ Pr	obably 4 Unknown
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Completed								perfor 1 □ Yes	med?	death?	2 No
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cei IIIIcailoii. 10	2 ☐ Accident 3 ☐ Suicide	investiga 6 ☐ Could no	ot be	of Injury - At hon	ne farm stre		Tes ZLINO	28f. Location /S	Street and Nu	mber or Ru	ral Route Number,
	4 ☐ Homicide	determir		ng, etc. (Specify)		ion motory, omico		City or Tow	n, State)		
	29a. Certifier (Check only		Physician: To the xaminer: On the b								
Medical	one)	1	and man	ner stated.					29d. Date sig		
_	29b. Signature and	utile of cortiller	XI	-		29c, Licens	61961		290. Date sigi		
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}	30. Name and add	1	the semi-late the	o of death (It	22a\ /T 1		01791		-	0	

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To Widowed 4 Notice of District Price Code Specify	Fun		Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (S an, Mexican, Pueri	Specify Yes or N to Rican, etc.)	0- 14.		
15. Mother's Name (First, Modific, Mastign Sumanne) 18. Mother's Name (First, Modific, Mastign Sumanne) 19. Mailing Address (Street and Number or Name Route Number, City or Town, State, Zip Code) 307	3 by		If Yes, Give		1 □Yes 2 ☑ No	Specify:		St		nite
Second Continued Continu	letec	15. Decedent's E (Specify only highest gi	ducation rade completed)	i (Give	kind of work done	during most of wor	rking	16b. Kind	of Business/In	dustry
Second S	E D		College (1-4or 5+)	lire.		,		Depar	tment o	of Energy
Robert Vernon Reichard Rey W. Lang / Husband 200. Method of Disposition 190. Method of Disposition 190. Method of Disposition 190. Disposition 21. Signature gathered Service Legence 22. Signature and Address of Service and Address of Service and Address of Service Stauffer Crematory Inc. 10 / 16 / 09 Frederick, Maryland 21. Signature gathered Service Legence Stauffer Crematory Inc. 10 / 16 / 09 Frederick, Maryland 22. Signature and Address of Service Stauffer Funeral Homes P. A. 1621 (Opns sumtrown Pite, Frederick, Maryland 2177) 23. Part I. Enter the disease, or complications plift caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Info21 (Opns sumtrown Pite, Frederick, Maryland 2177) 23. Part I. Enter the disease, or complications plift caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Info21 (Opns sumtrown Pite, Frederick, Maryland 2177) 24. Part I. Enter the disease, or complications plift caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Info21 (Opns sumtrown Pite, Frederick, Maryland 2177) 25. Part I. Enter the disease, or complications plift caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Info21 (Opns sumtrown Pite, Frederick) Sacuentify list conditions; In yes 2 plino Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a conseq			t)		Compacer		me (First, Middle			or micrey_
Ray W. Lang / Husband 307 Bellview Ave. Mt. Airy, Maryland 21771		Robert Vernon Re:	ichard			Helen Lo	ouise Sl	nahan		•
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Stauffer Crematory Inc.10/16/09 Frederick, Maryland 22. Name and Address of Facility 22. Name and Address of Facility 22. Name and Address of Facility 23. Sprature gut Prieral Service Logice 1621 Opnosium town Pike, Frederick, Maryland 2177. 238. Part I. Enter the disease, or complications (fifted and possible shock, or heart failure. List only one cause) on each line. 1621 Opnosium town Pike, Frederick, Maryland 2177. Approximate interest between Created and Death 1621 Opnosium town Pike, Frederick, Maryland 2177. Approximate interest between Created and Death 1622 Opnosium town Pike, Frederick, Maryland 2177. Approximate interest between Created and Death 1622 Opnosium town Pike, Frederick, Maryland 2177. Approximate interest between Created and Death 1622 Opnosium town Pike, Frederick, Maryland 2177. Approximate interest between Created and Death 1622 Opnosium town Pike, Frederick, Maryland 2177. Approximate interest between Created and Death 1622 Opnosium town Pike, Frederick, Maryland 2177. Approximate interest between Created and Death 1622 Opnosium town Pike, Frederick, Maryland 2177. Approximate interest between Created and Death 1622 Opnosium town Pike, Frederick, Maryland 2177. Opnosium town Pike, Frederick, Maryland 2177. Opnosium town Pike, Frederick, Maryland 2177. Opnosium town Pike, Frederick, Maryland 2177. Opnosium town Pike, Frederick, Maryland 2177. Opnosium town Pike, Frederick, Maryland 2177. Opnosium town Pike, Frederick, Maryland 2177. Opnosium town Pike, Frederick, Maryland 2177. Opnosium town Pike, Frederick, Maryland 2177. Opnosium town Pike, Frederick, Maryland 2177. Opnosium town Pike, Frederick, Maryland 2177. Opnosium town Pike, Frederick, Maryland 2177. Opnosium town Pike, Frederick, Maryland 2177. Opnosium town Pike, Frederick, Maryland 2177. Opnosium town Pike, Frederick, Maryland 2177. Opnosium town Pike, Frederick, Maryland 2177. Opnosium town Pike, Frederick, Maryland 2177. Opnos								_		
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DHMH 17 Rev 1/2001

09-08172 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 35341 Stephen Allen Murray State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day October 21, 2009 Medical Examiner 1300 hrs Stephen Allen Murray 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City. Town, or Location of Death Gregory Lane at Kempton Rd Oakland Garrett 5. Social Security Number If Under 1 Year If Under 24Hrs. 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY **Funeral** 7. Age (In vrs. last birthday) Months Davs Hours Min oreign Director 1 X M 2 F Country) 1957 218-64-7685 52 June 9, PA Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location Yes 2 X No hours after death with the Maryland MD 0akland Garrett Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 74 Gregory Lane United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces' 1 Never Married 2 X Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X No 10 Yes, Giva Year Divorce Yes 2 X No specify: Specify: narked other than "natural", event, the Medical Examiner White 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages I and 2 should be filed within 72 P Department of Health and Mental Hygiene. Important: If item 27 is marked other than "r 21215-0036 Coal Miner Mining 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) iant: If item 27 is marked or other traumatic event, t Be Allen Murray Joan McSorley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bessie Murray, Wife 74 Gregory Lane, Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, 1 X Burial 2 Cremation 3 Removal from State crematory or other place) 10/26/2009 Gregory Family Cemetery Oakland, MD Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home PA Sucition 21 N. Second St., Oakland, MD atherine Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line een Onset and /Medical Death Cardiac arrhythmia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Focal coronary atherosclerotic stenosis Sequentially list conditions. if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and AMENDED PI line a-b, 27, per ME g897 11/4/09 TT XUNPENDED IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery

Year

Day

death?

1 🗸 Yes

prior to completion of cause of

requires that the death certificate be executed Box 68760, Ö Records. The law Vital ₹ Division

Physician/Medical g physician a 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy certificate has performed? ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Be Hospital: 1 Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene this Inpatient ER/Outpatient 3 1 V Yes 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: X Natural Yes 2 No within 24 hours after death.

To the Funeral Director: Director: Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 22, 2009

111 Penn Street, Baltimore, MD 21201

ORIGINAL

State Registrar 32. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			1 - For State Regist <i>ra</i> r	State of Ma	Ce	ertificate of		rental Hygie	2009	35342
ı	Physici /Medic		Decedent's Name (First, Midd JOSEPH G	lle, Last) RAYSON	MAY	JR.		2. Date of Death Month OCTOBER	Day Year 15, 2009	3. Time of Death 09:06A M
	Examin		4a. Facility Name (If not institution FREDERICK MEM		.L	4b. City, Town, o			4c. County of Death FREDERIC	!K
	Funeral Director		5. Social Security Number 212–38–9457		68 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth Coul , 1941 Ma	place (State or Foreign ntry) ryland
	land ow		Usual Residence of Decedent 10a. State 10b. County	/	10c. City, Town or L	ocation		· · · · · · · · · · · · · · · · · · ·	1	10d. Inside City Limits
	a-f sh	ctor	Maryland Free	derick	New Mar	ket				1 ☐ Yes 2x No
	th with the 23a or 28 Ist be not	Funeral Director	10e. Street and Number 5747 Yeagertown	n Road		10f. Zip Code 2177 4	4	10g	g. Citizen of What Cour	itry?
215-0036	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Examinar, ust be neithed at		11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 🔀 Widowed 4 ☐ Divorce	If Yes Give	Ever in U.S. 13	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 2 No		ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
15-0	"natu	Completed by	15. Decede (Specify only high	nt's Education est grade completed)	(Giv	edent's Usual Occup e kind of work done DO NOT use retire	during most of work		6b. Kind of Business/In	dustry
212	l within giene. r than "	dwo	Elementary/Secondary (0-12)	College (1-4or 5-	+) _	sperson	0)		Plumbing	
Maryland 2	should be filed vand Mental Hygir s marked other	To Be C	17. Father's Name (First, Middle Joseph G. May					(First, Middle, Ma	,	
lary		-	19a. Informant's Name/Relation						City or Town, State, Zip	
	1 and 2 Health em 27 i	3	Joseph May, II	I – Son					et, Maryla	
Baltimore,	permit. Pages 1 ar Department of Hez Important: If item any injury or othe once.		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 4 ☐ Donation 5 ☐ Other (Specify)	Stauffer	position (Name of ematory or other pla Crematory	7 10-17	-2009 Fr	ederick, M	aryland
Bal	permil Depar Impor any ir		21. Si parure of Funeral Service	amille G	lene		sumtown Pi	ike, Fred	Funeral Herick, Mar	
	Physician /Medical Examiner	ľ	23a. Part1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a. ue to (or as a	a consequence of):				e alsees	Approximate Interval Between Onset and Death
	ecuted and transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of):					
68760,	tificate be executed g physician and as the burial-transit	edical Ex	resulting in death) Last	d.	a consequence of):					
O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗍 Fetal death 3	Ectopic pregnanc	су		23d. Date of deliv Month	ery Day Year
ds, P.	uires that signed b Id be deta		Part II. Other significant condit	ions contributing to death bu	it not resulting in the	underlying cause giv	ven in Part I.		acco use contribute to t	
al Records,	siclan: The law requir certificate has been s rector, page 2 should	Completed by	sleep'	morbie	alred	the of	struction	224a. Was an autopsy performe 1 □ Yes 2ft	prior to co	opsy findings available ompletion of cause of
Vital	Physiclan: r this certific ral director, p	o Be	25. Was case referr o modic examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpati	ent 3 DOA Oth	000	h (Check only one)	ice 6 🗆 Other (Speci	(64)
on of	ng The	tion: To	27. Manner → eath 1 — atural 5 ☐ Pendi	28a. Date of Injur	ry 28b. Time	of 28c. Inju		28d. Describe how		<u>''</u>
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could	not be mined 28e. Place of Inju- building, etc	iry - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
	e Hospita 124 hours e Funeral letely fille	Medical C		ing Physician: To the best of I Examiner: On the basis of and manner sta	examination and/or					
	To the To the comp	Me	29b. Signature and title of certifi	er Olo a	TEX 12	29c. Licens	se number	3 290	d. Date signed (Month,	Day, Year)
	17		30. Name and address of perso	n who completed cause of d	eath (Item 23a) (Type	e, Print)	2010 Lotte-	1 42	En 1	1000g
Y	Sta		31. Date filed (Month, Day, Year		S Signature	had I	19195	Treel	rederi	ck, MI)
	Registr	ar	UC1	19 2009 ▶ 🔑	enerous for	19 com				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 10 2009 Year **Physician** 16 35 PM Norbert Lee Mason /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 161 Sunshine Lane Ocean City Worcester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/15/1936 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Country) 1 € M 2 □ F 73 212-36-3855 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🕅 No Director MD Worcester Ocean City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 161 Sunshine Lane 21842 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 □X(es 2 □ If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Banker Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Norbert Leen Mason Anna Marie Whalen Department of Health and Important: If item 27 is ma any Injury or other traumaren. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole J. Mason / wife 161 Sunshine Lane, Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal from State 10/19/2009 Frankford, DE Cape Henlopen Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service 108 William St., Berlin, MD 21811 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pulmonary Fibrosis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Error Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? 1 ☐ Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1∐ Yes 2 🛣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending after death.

Director: Aft of in by the further investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

ET 5+1

State Registrar Anthony J. Perella, Jr. MD
31. Date filed (Month, Day, Year)
32. Registra

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1r. MD 9733 Healthway Dr., Berlin, MD 21811
32. Registrar's Signature

D64585

10/19/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0830AM Marie Doris Moore Octob 2009 21 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Washington County Hospital Washington 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 🖸 F 78 217-28-6502 19. December 1930 Marvland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 La Yes 2 La No Washington Hagerstown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 410 Guilford Avenue 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married 1 □Yes 2X No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Charles Reese Elsie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Guilford Avenue, Hagerstown, Maryland 21740 Jerry S. Moore Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) ₿enevola U.M. Church Cem.10–24–09| Boonsboro, Marvland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Andrew K. Coffman Funeral Home, Inc. R. hoel Brady 40 East Antietam Street, Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Premionia Due to (or as a consequence of): Lung CHNICOL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IN FARC MON ACUTE MYOCALDIAL Due to (or as a consequence of): GBSTRUCTIVE PULMONARY If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 I Unknown iditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinations the routinal at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Magnotics.

Completed by

Be

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requires that the death certificate be executed and burial-trar attending physician for use as the buria signed by the atte

Examiner Physician/Medical ģ Completed Be Certification: To

funeral director, page 2 should After this Phospital or Attending Plant Standing Plant Steer death.
Funeral Director: After the standing Plant Standing Pl sompletely filled in by the within 24 hours a

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown
Part II. Other significant con

3 Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

FIBRILLATION RESPIRATORT

1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy

1 ☐ Yes

26. Place of Death (Check only one)

2 No

28d. Describe how injury occurred

ST. HAR ORSTOWN

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1	Inpatient	2 🗆	ER/Outpatient	3 🗆 [_ D
. Man, r of Death 1 ♥ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. D	ate of Injury Month, Day, Ye	ar)	28b. Time of Injury	M	

CHRONIC

Other: 4 Nursing Home 5 Residence 6 Other (Specify) OA 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifie

6 Could not be determined

29c. License number 000 62006

ANTIETTM

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

251 AWAKO WIRDU

State Registrar

31. Date filed (Month, Day, Year) OCT 23



N3H-4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Item Registrar	State of Ma 25 per me,	ryland (f	epartmer /06/09di Certificat	it of - n b,2 3	lealth a Death	and Mental Hy	ygien Reg. N	e .2111	3531.5
	Dhysisi		Decedent's Name (First, Middle, L						2. Date of D Month	eath	ay Year	3. Time of Death
	Physici /Medio		Stephanie	McNeill		41. 0:4.	Ta	Location of	Octob	2	7 2005 c. County of Dear	
4	Examin	er	4a. Facility Name (If not institution, g	land medica	1 (2-42			Marce		4	c. County of Dea N/A	tn
	Funeral		5. Social Security Number 6.	Sex 7. Age 1 ☐ M 2 💢 F	(In yrs. last bir	thday) If Unde		If Under 2 Hours	24 Hrs. 8. Date of B	lav Year	9. Bir	thplace (State or Foreign
	Director		Usual Residence of Decedent	1 L M 2 X F	43	Yrs.			May 28	3, 1	966	Maryland
	yland now		10a. State 10b. County		10c. City, Towr	or Location						10d. Inside City Limits
	e Mar	ctor	Maryland Ceci	.1	Ris	sing Sun						1 □Yes 2 💢 No
	ith the	Director	10e. Street and Number			10f. Zip				10g. C	citizen of What Co	ountry?
	eath w	Funeral	425 Telegraph F	12. Was Decedent Ev	ver in IIS	13 Was Dece		21911	nin? (Specify Ves or N	lo-	USA 14. Race - Ame	erican Indian
	5-0036 72 hours after death with the Maryland natural", or items 23a or 28a-f show dieal Exprimer fourt be recified at		11. Marital Status1 ☐ Never Married2 ☐ Married	Armed Forces? 1 ☐ Yes 2 📆 No					gin? (Specify Yes or N , Puerto Rican, etc.)		Black, Whit	
	21215-0036 d within 72 hours aft gliener than "natural", or the Medical Exernii	d by	3 Widowed 4 X Divorced	If Yes, Give Year or Dates:		1 □Yes		Specify:			Specify:	White
	15-(Completed	15. Decedent's (Specify only highest of		16a.	Give kind of wo life. DO NOT u	al Occup ork done o	ation during most	of working	16b.	Kind of Business	/Industry
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	al Hyg	BeC	17. Father's Name (First, Middle, La	st)				18. Mother	r's Name (First, Middl	e, Maide	en Surname)	
	arylan(should be f and Mental I s marked of	일	Ernest McNeill					Ru	th Goss		<u></u>	
	Maryland nd 2 should be file alth and Mental Hy 27 is marked oth		19a. Informant's Name/Relationship		1		•		r or Rural Route Num			Zip Code)
	tem 2		Ruth McNei11/Mc	tner		Disposition (Natry, crematory or c		i	ng Sun, MD		L911 Location - City or	Town, State
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show with july or other traumatic event, the Medical Exprintmer inter the notified at once.		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		1	ingo Bap		1 -	0-21-2009 terv	Cor	nowingo.	Maryland
	Balti permit. Departm Importa any Inju		21. Signature of Funeral Service Lic		, 00110				neral Home			
	10 gg = # 9		Tuchard &	. Goodie		111	s. Q	ueen l	St., Risin	g St	ın, MD	21911
73			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplical ins that caused to ly on ause on each line	he death. Do	not enter the mo	de of dyir	ng, such as i	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	un de	The state of the s						-lday
	Examiner			bue to (or as a	3CCC	V 11	mer	chac	0			1 day
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10	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	consequence	ofl:		7	CO BY MEDICAL EX	AMINER		
	8760, rate be executed hysician and the burial-transit	ical E		2 de 10 (01 de d	oonsequence .	01).	CERTIF	ICATION APP	PROVED BY MEDICAL EX			
	Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledic		d			OLA					
	Box 68 eath certifica attending ph for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o		3 ☐ Ectopic	oregnand	V			23d. Date of de Month	elivery Day Year
	O. E	/sici	1 ☐Yes 2 ZNo 9 ☐ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown		5 Other (s		,			MOTH	Day real
	Cords, P.O. **requires that the dispense signed by the should be detached.	/ Ph	Part II. Other significant conditions	contributing to death but	not resulting in	n the underlying	ause giv	en in Part I.	23e. Dio	d tobacco	o use contribute t	to the cause of death?
	rds quires an sign	d by							10	Yes	2 □ No 3 □ F	Probably 4 Unknown
	Reco e law red has bee	Completed							24a. Wa		24b. Were a	utopsy findings available completion of cause of
!	The The page	Som							per 1 □ Yes	opsy formed? 2 🔀	death?	s 2 No
	Division of Vital Records, I or Attending Physician: The law requires th after death. Director: After this certificate has been signe tin by the funeral director, page 2 should be	Be	25. Was case referred to medical examiner?	Hospital:			OA Oth	OF:	of Death (Check only			
•	Of Phys or this oral dir	۲: ح	11 Yes 27 Nanner of Death	1 ☐ Inpatier 28a. Date of Injury (Month, Day,		tpatient 3 D	OA Our 28c. Injur Wor	4 🗆 Nu	rsing Home 5 Re		6 ☐ Other (Sp. jury occurred	ecify)
	ion arth. r: Afte	Certification:	1 Natural 5 Pending 2 Accident investigat		Year)	njury M		ki? Yes 2∐1	No			
	IVIS	tific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		y - At home, fa (Specify)	ırm, street, factor	y, office		28f. Location City or T	(Street own, Sta	and Number or F	Rural Route Number,
i	Dital o		00- 0						1 1		()	
	Division To the Hospital or Attendin Within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Medical		Physician: To the best of aminer: On the basis of and manner stat	examination ar							
	To the within To the Compl	Me	29b. Signature and title of certifier			29	c. Licens	e number		29d. [Date signed (Mon	th, Day, Year)
٠, ١			100 100	anon		1	023	327 4	1284	000	tober 1	7.2009
Celei	۵		30. Name and address of person wh		,	(Type, Print)			•			,
	<i>ξ</i> Sta	ıta.	Jill Halanen, N 31. Date filed (Month, Day, Year)	1.D., Univ. 32. Registra		Med. Ctr	., 2	2 S. (Greene St.	, Ba	altimore	, MD 21201
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 35346

Taw	anda Renee	1	- For State	state of Ma	ryland / I		rtment of tificate of			Menta	al Hyg		2 0 g. No.	09	3534
	Physicia	an/	Registrar 1. Decedent's Name (First, Mid	ldle,Last)								Date of Deat Month	Day Year	3. Time o	
Me	dical Exami		TAWANDA RENE						1			October 20), 2009 4c. County of Dea		.1115
			4a. Facility Name (if not institute 1161 Southview Driver)		id number)		1	b. City, To Oxon H		ocation of	Death		Prince Georg		
	Funeral		5. Social Security Number	16. Sex	7. Age ((In vrs. la	st birthday)	If Under	1 Year	If Under	24Hrs. [8	3. Date of Bir	h(MM/DD/YYYY) 9. E	3irthplace (S	tate or
	Director		0527	1 M 2 X			Yrs	Months	Days	Hours	Min.	11/7/1		Company of	ington DC
		ŀ	577-98- 0627 Usual Residence of Decedent			33		1	L	1	L. —	11///1	973		
	any	İ	10a. State 10b. Count	у	1	0c. City,	Town or Locati	on							de City Limits
	ınd show nce.	5	Maryland Princ	e George	's	0xo	n Hill							-	es 2 No
P	daryla 28a-f 1 at o	rector	10e. Street and Number					10f. Zip (ode			1	0g. Citizen of What Co	ountry?	
N	r death with the Maryland or items 23a or 28a-f show must be notified at once.	آة	1161 Southview					207	45			I	nited Star		- Dii
N	th with	eral	11. Marital Status 1 Never Married 2 🛣		Decedent E ed Forces?	ver in U.S	S. 13. Wa	s Deceden es, specify	t of Hisp Cuban,	anic Origi Mexican,	n? (Spec Puerto Ri	ify Yes or No can, etc.)	- 14. Race - Am White, etc		п, васк,
1	er deal	Fun		Divorced If Yes, Give		X No	1	Yes 2	No	specify:			Specify: B	Lack	
	215-0036 be filed within 72 hours after death with the Maryland nutal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	5	15. Decedent's Education (S	or Dates:		leted)	16a. Deceden	it's Usual C	ccupatio	on (Give k			16b. Kind of Busines		
	72 hou	Completed	Elementary/Secondary (0-1		ege (1-4 or 5+		during m	ost of work	ing life. I	DO NOT L	ise retired	1)	1		
	036 ithin 7 ne. r thar	힅	12				Secu	rity	Off	icer			Guards Ma	ark Se	curity
	5-0036 iled within 7/ Hygiene. I other than the Medical		17. Father's Name (First, Midd	lle, Last)				.	1	8.Mother's	Name (F	irst, Middle,	Maiden Surname)		
	121 d be fi lental J arked	o Be	Beverly McEac	hin			10h Mailin	Addross	(Street	Conni	e Mc	Eachir	nber, City or Town, St	ate Zin Cod	e)
	Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than 'injury or other traumatic event, the Medical injury or other traumatic event, the Medical												gton, DC		-,
	and 2 sho lealth and tem 27 is traumati		Connie McEachi 20a. Method of Disposition				Place of Dispos	ition (Nam				Date	20c. Location - City	or Town, St	ate
	More Pages 1 a nent of He ant: If it		1 X Burial 2 Cremat		val from Stat	~	crematory or ot				10/0	0/2000	C. i. lan	1 Man	1
	Itir nit. Pa artmer ortan ry or		4 Donation 5 Other 21. Signature of Funeral Servi	Specify: ce Ligensee		L11	ncoln M	Name and	Address	of Facility	10/2	Funers	Suitland 11 Homes, 1	r Mar	yrano
	Baltil permit. Departm Imports		KOTHO	10,00	MI	CUF	T 55	38 Ma	r1h	oro F	like	Forest	ville. Mar	rvland	20747
	Physician	Τ.	23a. Part . Enter the dise e, failure. List only on cau	or complications	that caused t	he death	. Do not enter t	he mode o	f dying, s	such as ca	rdiac or r	espiratory ar	rest, shock, or heart	Appro:	ximate Interval een Onset and
10	/Medical		Immediate Cause (Final disea	ase a. Id:	iopath:	ic s	eizure	diso	rder					4_	Death
_).		or condition resulting in death	Due to (c	or as a consec	quence o	of):								
		-	Sequentially list conditions, if any, leading to immediate	b Due to (c	r as a conse	quence o	of):								
	_	Examiner	(Disease or injury that initiate	d C.										-	
	ted Insit	Exa	events resulting in death) Las	st Due to (d	or as a conse	quence o	и):							1	
	0, e be executed ysician and burial - transit	dical	X UNPENDED	X AMEN	DED #5pe	rFH	,G900,2	/23/2	010	,WS	///	mm			
	60, ate be hysici e buri		IF FEMALE:	23c. l	23a, f yes, outcom	e of preg	,6900,2 <u>27,pern</u> mancy	i,E go	59/	11/24	1709	TT	23d. Date of deli	very	
	Sox 68760 leath certificate be attending physi for use as the bu	cian/M	23b. Was decedent pregnant in past 12 months?	1 =	Live birth	ima of de	ooth -	etal death	3	Ectopio	pregnan	су	Month	Day	Year
	Box e death ce the attened	/sici	1 Yes 2 V No 9	Helianium 7 =	Pregnant at t Unknown	unie oi de	5 O	ther (Spec	ify) _						
	O. Bat the de d by the etached	Physi	Part II. Other significant con			but not r	resulting in the	underlying	cause g	iven in Pa	ırt I.		tobacco use contribut		
	s, P.O. Be irres that the de rigned by the	Ş	Severe cord	nary atl	nerosc	1ero	sis	_				1 Ye	es 2 🗸 No 3	Probably 4	Unknown
	Vital Records, hysician: The law requir this certificate has been s I director, page 2 should I	Completed										24a. Was			dings available on of cause of
	e law te has ge 2 sl	ם		-									ormed? deat	h? Yes	2 No
	tal Rection: The Jectificate ector, page		25. Was case referred to med	fical	<u>.</u>				26.Place	of Death	(Check o	niy one)			
	Vital F hysician: this certifi	o Be	examiner? 1 ✓ Yes 2 No	Hospital:	1 Inpatie	nt 2	ER/Outpatier	nt 3 🗌 D	OA	Other ₄	Nursing	Home 5	Residence 6 🗸 C	ther: Scene	
	of John Of Jing Ph	끝	27. Manner of Death	28a	. Date of Injur (Month, Day, Ye	ry ear)	28b. Time of	Injury		ry at Work	. 1	28d. Describe	e how injury occurred		
	ion ttendi death. tor: ,	aţi		Pending nvestigation						Yes 2	-	201	(Otalian de la Normania de la Colonia de la	a Dural Bord	o Number City
	Division tal or Attendir rs after death. all Director: Aled in by the ft.	Certification:		could not be		jury - At h	nome, farm, str	eet, factory	, office b	uilding, e	ic.	or Town,	(Street and Number of State)	r Rurai Rout	e Number, Only
	프 등 등 교		4 Homicide		pecify)	, knoudo	dae death eco	urred at the	time d	ate and ni	ace and	tue to the ca	use(s) and manner as	stated.	
	To the Hos within 24 h To the Fur completely	Medical	(Check only 1 Certifying one) 2 Medical I	Examiner:On the	basis of exar	mination a	and/or investig	ation, in my	opinion	i, death o	curred at	the time, dat	e and place, and due	to the cause	(s)
	To To	Mec	29b Signature and title of ee		nner stated.	1		29	. Licens	e number			29d. Date signed	(Month, Day	, Year)
			9)46	the	1006	my	50		O.C.	M.E.			October 21, 2	2009	
			30. Name and address of per	son who complete	ed cause of d	eath (Iter	m 23a)								
CAR			Victor Weedn MD J		nt Medical			Penn St	reet, E	Baltimor	e, MD 2	21201			
	S	tate	(1111 60 60 1111	10	32. Registra	Signat	backer								
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Andrew C. Neidinger 2009 /Medical October 0 9:10a 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death <u>College View Nursing Home</u> Frederick Frederick If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F **Director** 577-48-7696 79 Dec. 20, 1929 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Evaniner must be notified at Directo Maryland Calvert Lusby 1 ☐ Yes XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 665 Miriam Lane 20657 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 2 □ No Maryland 21215-0036 1 ☐Yes 2 → No ğ Specify: white 3 ☐ Widowed 4 ☑ Divorced "natural", Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 0wner Home amusement company 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event once. Be 18. Mother's Name (First, Middle, Maiden Surname) Andrew C. Neidinger Nora O'Connor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Neidinger - son 665 Miriam Lane, Lusby, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) 10-18-2009 Frederick, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stauffer Funeral Home gamelle 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To the Hospite. ...
within 24 hours after death.
To the Funeral Director. After this ce Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐No 2 Accident 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 141 Shah

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrat's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Bertha Elizabeth Odom October 6 1 18,2009 /Medical 2:05 P. 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 ☐ M 2 🔀 F 578-34-5588 **Director** 10/25/1924 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner roust be notified at Director 1⊠Yes 2□No Md. P.G. Fairmount Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5503 Jefferson Heights Drive Be Completed by Funeral 20743 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: African-1 ☐ Yes 2 XNo Specify: 3X Widowed 4 ☐ Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) \$2 should be fight and Mental H Horace E. Johnson Emma Bailey ည other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Marcella N. Odom/Daughter 5503 Jefferson Heights Dr., Fairmount Hgts., Md. 20743 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, S. 1 Burial 2 Cremation 3 ☐ Removal from State Harmony Mem. Park 10/23/09 4 Donation 5 ☐ Other (Specify) Landover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility H.S. Washington & Sons Co, Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 Kany 1 als 23a. Part1. Eller the diselse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading of minimal attactions. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760 Physiclan/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was ar performed? Yes 2 No 2 🗆 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after deatl 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00066940 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Ping Li, M.D.

31. Date filed (Month, Day, Year)

3001 Hospital Drive, Cheverly, Maryland 20785

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Kate LeJeune Petty October 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 214 Harbor Drive Lusby Calvert . Social Security Numbe Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖔 F Days Months 06-15-1920 Utah Hours Director 529-10-4577 89 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🗆 Yes 2 🗓 No Marvland Calvert Lusby 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 214 Harbor Drive 20657 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Social Worker Red Cross Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 Violet Kathleen Lloyd Samuel Isaac Wagstaff permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 42839 Churchill Downs Drive, Ashburn, VA 20147 Susan Petty Hathaway (Daughter) 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Middleham Chapel Cem. 10/19/2009 4 ☐ Donation 5 ☐ Other (Specify) Lusby, Maryland 21. Signature of Funeral Service Mcenses 22. Name and Address of Facility Rausch Funeral Home, P. A. 0. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner If any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events executed use as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 - Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month 5 Other (specify) Pregnant at time of death 9 Unknown the detached 9 Unknown sate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 →No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform certificate 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, å 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52242 October 14, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRW 10 John Barth, MD, 110 Hospital Rd., Suite 310, Prince Frederick, MD 20678

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registra s Signature

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 9

Physic /Medi Exami **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example countries in purified at once. Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

15	
Sta Registr	

	Registrar	Cei	rtificate of L	Death	Reg.	Vo. 2009	35350						
an	1. Decedent's Name (First, Middle, Last)	•			2. Date of Death Month October 1.	Pay 200Year	3. Time of Death						
al	Mildred Hurley Phill					1 ^{2ay} 200 ^{9ear} 1:20 а.м							
er	4a. Facility Name (If not institution, give street and number	er)	4b. City, Town, or		1	4c. County of Death							
	Chesapeake Woods Center		Cambr:	-		Dorchest							
	1□ M 2 X 3 E	Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day, Yea	9. Birthp	place (State or Foreign ntry)						
	215-03-2593 Usual Residence of Decedent	96 ^{11s.}			Sept. 30	1913 Mary	yland						
	10a. State 10b. County	10c. City, Town or Lo	ocation			11	0d. Inside City Limits						
ō	MD Dorchester	, , , , , , , , , , , , , , , , , , , ,	Cambri	dao			1 X Yes 2 □ No						
ect	10e. Street and Number			uge	10-	Citizen of What Cour							
ä	1104 Glasgow Street		10f. Zip Code	21613	109.	USA	III y ?						
eral			111										
ş	11. Marital Status 12. Was Deceder Armed Force:	it Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S) n, Mexican, Puert	oecity Yes or No- o Rican, etc.)	14. Race - Americ Black, White,							
Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 √Yoldowed 4 Divorced Year or Dates		1 □Yes 2 No	Specify:		Specify: W	nite						
ed	15. Decedent's Education		dent's Usual Occupa	ation	16h	Kind of Business/In	duetry						
Set	(Specify only highest grade completed)	(Give	kind of work done d DO NOT use retired	luring most of worl	king	Kind of Business/iii	uustry						
E	Elementary/Secondary (0-12) College (1-4o	r 5+)	operator	,		telepho	one						
ŭ	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ue (First, Middle, Maid								
o Be	Leslie Hurley			Ethel 8									
ပ္	19a. Informant's Name/Relationship (Type. Print)	40h Main-	na Address (Ctrast		ral Route Number, Cit	V 05 Town 04-4- 7'-	Cadal						
	Sandy Raymond niece				Cambridge		′						
	20a, Method of Disposition					MD 2161							
	1 Burial 2 ☐ Cremation 3 ☐ Removal from State												
	4 ☐ Donation 5 ☐ Other (Specify)		Market Co			ast New Ma							
	21. Signature d'Funeral Service Licensee	ral Home H	P.A.										
_	700 Locust St., Cambridge, MD 21613												
	23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do not ent line.	ter the mode of dying	g, such as cardiac	or respiratory arrest,		Approximate Interval Between						
ĺ	Immediate Cause (Final disease or condition Onset and Death 302.5												
resulting in death) Due to (or as a consequence of):													
.	Sepsis												
ne	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury												
am	that initiated events C.												
Щ	resulting in death) Last Due to (or a	is a consequence of):											
n/Medical Examiner	d												
Med	IF FEMALE:												
ar/	23b. Was decedent pregnant 23c. If yes, outcom		☐ Ectopic pregnancy			23d. Date of delive	•						
Sici	1 Yes 2 No	at time of death 5	Other (specify)			Month	Day Year						
ř	9 □ Unknown 9 □ Unknowr												
Be Completed by Physicial	Part II. Other significant conditions contributing to death	but not resulting in the ur	nderlying cause give	n in Part I.	23e. Did tobacc	o use contribute to the	he cause of death?						
8	dementia				1 ☐ Yes	No 3□ Prot	pably 4 ☐ Unknown						
et					24a. Was an	24b. Were auto	psy findings available						
E				<u>. </u>	autopsy performed 1 □ Yes 2	prior to co death?	mpletion of cause of						
ပို	25. Was case referred to medical	No 1 □ Yes	2 ∐No										
ă	examiner?	examiner?											
Ĕ	27. Manner of Death 28a. Date of Ir	iury 28b. Time of	f 28c. Injury	at Nursing H	ome 5 ☐ Residence 28d. Describe how in		<i>y</i> /						
흲	Natural 5 Pending (Month, I	Day, Year) Injury	Work'	? ′es 2 □ No		ja. y oodan oa							
2	a Cloude not be	and Number or Rura	I Pouto Number										
Ę	4 Homicide determined 28e. Place of I building,	ate)	ii riodie Nambei,										
Medical Certification: To	29a. Certifier Certifying Physician: To the be	Da. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner a											
dica	(Check only one) 2 Medical Examiner: On the basis and manner:	and place, and due to	the cause(s)										
Mec	29b. Signature and title of certifier		29c. License	number	204	Date signed /Month	Dav. Year)						
	I pluson il		H	005 99	13 /	0/10/09							
	30. Name and address of person who completed cause of	death (Item 23a) (Type, I	Print)	1	, ,	n							
	Patrica Johnson	100 Bran	nove (-am or	idge Fil								
e Ir	31. Date filed (Month, Day, Year) 32. Reg	trar's Signature	barre										
	001 0000	W. 1											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 28a. per ME 9897 11/6/09 TT.

			1 - State 10-21-09 Registrar Ameno#1 Pero	State of Ma overingDr.PGO	br	Cei	rtificate of I		nd Mental F		2009	3535
	Physic	an	1. Decedent's Name (First, Middle, L. Dion	M. Prout	Ir. o	00			2. Date of Month	Death Day	Year	3. Time of Death
	/Medi	cal			77	NOU		1 1 4	OCTOB	BR 11	2009	5105 PM
	Examir	ner	4a. Facility Name (If not institution, gi	·	DICAL C	ENTER	4b. City, Town, or BAC	Location of I		4c. 9	County of Death	1
	Funeral	Г	Social Security Number 6.		e (In yrs. last I	birthday)	If Under 1 Year Months Days	If Under 24		Birth Day, Year)	9. Birth	nplace (State or Foreign untry)
	Director		577-17-4152 Usual Residence of Decedent	TIZAM 2LIF	25	Yrs.	mendie Dayo			-/1983		DC
	/land		10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
	a-fsh	ctor	MD Prince	George's	Боь	vie						1 X]Yes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	untry?
	sath w	eral	15119 Jenkins Ri	dge Rd. 12. Was Decedent B	Ever in LLC	10.1	20721	lianania Oriali	-2 (Casaity Van au	No. 1	AZU	iona Indian
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show amy fortung or other traumatic event, the Medical Exerciper must be notified at once.	by Funeral	11. Marital Status1 Never Married 2 Married3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 X			Was Decedent of H fYes, specify Cuba I □Yes 2 No	an, Mexican, I Specify:	Puerto Rican, etc.)		4. Race - Amer Black, White Specify: B1	ack
15-0	n 72 ho "natur	Completed	15. Decedent's E (Specify only highest g	ducation rade completed)	16	Sa. Deced	dent's Usual Occup kind of work done o OO NOT use retired	ation during most o	f working	16b. Kir	nd of Business/I	ndustry
2121	2 should be filed within and Mental Hygiene. is marked other than aumatic event, In Me	шо	Elementary/Secondary (0-12)	College (1-4or 5	⁺⁾ F		ighter	-/		D.C.	Fire D	epartment
	e filec al Hyg I othe went,	Be C	17. Father's Name (First, Middle, Las	t)	•			18. Mother's	Name (First, Mide			•
yla	ould b i Ment rarkec	2	Dion M. Prout						a Johnsor			
Maryland	d 2 sh Ith and 17 is n traun		19a. Informant's Name/Relationship Dion M. Prout, SI		1		ng Address <i>(Street i</i> Jenkins					ip Code)
	s 1 an if Heal item 2 other	-	20a. Method of Disposition				sition (Name of natory or other place		Date		cation - City or T	Town, State
m	Page nent c int; If ury or		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		Fort			i	20/2009	Bren	atwood.	MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trat once.	1	21. Signature of Funeral Service Lice	ensee	1/1		. Name and Addres	ss of Facility	Strickla	and Fu	neral S	ervices
	<u> </u>		23a. In the disease, or mind	Truff-	The death D		00 Alleni				gs- MD	20748 Approximate
	Dharida		shick, or heart failure. List only	one cause on each lin	ie.					,		Interval Between Onset and Death SDAYS
,	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	a consequenc	e of	BRAII			_		SPARS
1	Examiner		Sequentially list conditions	. ACUTE	RBS	PIR	ATORY	DIST	RESS S	HNDF	ROME	2 DAYS
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequenc	e of):			106	THE EL	N. S. S. S. S. S. S. S. S. S. S. S. S. S.	
_,	execut n and al-tran	xan	that initiated events resulting in death) Last	c Due to (or as a	a consequenc	e of):			16 Aller	M MEDIA		
68760,	rtificate be executed ng physician and as the burial-transit	edical		d				(0/ Juli	THE CATION IN PROPERTY.			
Box (Attending Physician: The law requires that the death certific refeath. ector: After this certificate has been signed by the attending I by the funeral director, page 2 should be detached for use as	M/ue	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		ath 3 F	Ectopic pregnanc				3d. Date of deli	
O. E	at the dea by the at tached fo	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)	<i>y</i>	<u> </u>	-	Month	Day Year
σ.	that the ed by detac		Part II. Other significant conditions	contributing to death bu	ut not resulting	in the ur	nderlying cause give	en in Part I.	23e. D	id tobacco us	se contribute to	the cause of death?
rds	quires tha n signed ald be det	d by							11	⊒Yes 2	No 3□ Pro	obably 4 🗆 Unknown
of Vital Records,	e law requir has been s ie 2 should	Completed							24a. W			topsy findings available
E E	The cate has page	Com							pe 1 □ Ye	itopsy informed? s 2 1 No	death?	completion of cause of 2 No
Vita	ysician; The ils certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe		f Death (Check on			
of	aling Phys n. After this funeral dii	7: To	1XYes 2 □ No 27. Manner of Death	28a. Date of Injur		. Time of	1 3LI DUA	4 LJ Nurs	ing Home 5 ☐ R	esidence 6 be how injury	- ' '	cify)
ion	ktending F death. ctor: After y the funer	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day on OCTOBER 7		S 0 C	World 1□	ć? Yes 2.MΩNo				COLLISION
Division	or Atten after deat Director:	Certification:	3 Suicide 6 Could not I 4 Homicide determined	De 280 Place of Init	ry - At home, . (Specify)	farm, str	eet, factory, office		28f. Location	(Street and Town, State)	Number or Ru	ral Route Number,
Ω	ospital or A hours after ineral Directly filled in by		200 Cartifier 19 Cartifilms D		SW	427		11 - 1	RT1	11 A7	rewar	r mill Rd
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 12 Certifying P 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination i	and/or in	vestigation, in my o	ppinion, death	occurred at the tin	ne, date and	place, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	1	_		29c. Licenso				e signed (Month	_
			M	M. M.C			RE.	5 00	00	007	OBER	11,2009
D	10		30. Name and address of person who MANJUNATH	completed cause of de	eath (Item 23a	a) (Type,	Print)	OR M	ARULAN	n ME	DICAC	CENTER
1		1 1			11011	01.	2118	0	- コレハック		UL CONT	

State Registrar

31. Date filed (Month, Day, Year) OCT 2 1 2009

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland /	Department of Heal Certificate of Dea		Hygiene Reg. No. 2009	35352
			Registrar 1. Decedent's Name (First, Middle, Last)		Oct another of Bot	2. Date of Month	f Death	3. Time of Death
	Physicia /Medic		Helen Mar	ie Rowe		/	0/17/2009	06:12 AM
	Examin	er	4a. Facility Name (If not institution, give s	1 11 1	4b. City, Town, or Loca	ition of Death	4c. County of Death	1
	Funeral		5. Social Security Number 6. Sex			Under 24 Hrs. 8. Date of Ours Min. (Month	f Birth 9. Birthp	place (State or Foreign
	Director		334-32-040X	IM 278 8/	Yrs. Wortins Days Tio	11/6		"MD
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	vn or Location		1	0d. Inside City Limits
	e Mar 8a-f sl	Director	MD Cecil	Elk	ton			1 □Yes 2 □ No
	with the	Dir	10e. Street and Number	Shoot	10f. Zip Code	21921	10g. Citizen of What Cour	ntry?
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispan If Yes, specify Cuban, Me		0	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be rediffied at once.	y Fu	1 Never Married 2 Married	1 ⊟Yes 2 No If Yes, Give	_ ~/	pecify:	Specify: \ //	10
21215-0036	2 hour atural	Completed by	3 Widowed 4 ☐ Divorced 15. Decedent's Educ		a. Decedent's Usual Occupation		16b. Kind of Business/In	dustry
215	within 7; iene. than "n	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during life. DO NOT use retired)	j most of working	10.44	0/0 - 0
d 21	filed w Hygiel other th		17. Father's Name (First, Middle, Last)		tomemaker 18.1	Mother's Name (First, Mid		ome
lan'	Aental rked o	To Be	Pat Dewey Wo	tters	1	ottie Be	LL (05bo	rne)
Maryland	2 should n and Mer is marke raumatic		19a. Informant's Name/Relationship (Ty)		b. Mailing Address (Street and N	Number or Rural Route No	umber, City or Town, State, Zip	A L
	1 and Health em 27		Larry Kirby 20a. Method of Disposition	/ Son 23	3 JUSCAN (70 of Disposition (Name of ery, crematory or other place)	alleher D	20c. Location - City or To	$\sqrt{\frac{21921}{\text{own, State}}}$
mor	Pages nent of I ant: If its iry or o		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State 1	ery, crematory or other place) awn Mempyial Parl	x 10/21/200	09 OAK HILL	WV
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service License		22. Name and Address of 5+varo + Feel	Facility	Funeral Home	,
	20 E # 9	-	23a. Part 1. Enter the disease, or compli	The state of the death D	635 Churchma	arts Road	Newark DE	970 2 Approximate
2.	Physician		shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.	of Pancreas		tatasin	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence	4	Win ine	luyasis	ואומייי
	Examiner	Į.	Sequentially list conditions,	Due to (or as a consequence	a of).		-	
	cuted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a someoquemon				
ő,	icate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequence	e of):			
38760,	ficate to physical to the part of the part	edical		i				
Box (death certific e attending p d for use as	In/Me	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Feta! deal	th 3 □ Ectopic pregnancy		23d. Date of deliv	
O. B	0 0 0	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of death			Month	Day Year
, P.O.	The law requires that the di ate has been signed by the bage 2 should be detached		Part II. Other significant conditions cor	ntributing to death but not resulting	in the underlying cause given in	Part I. 23e.	Did tobacco use contribute to t	the cause of death?
Division of Vital Records,	equires en sigi ould be	ed by					1 ☐ Yes 2 ☐ No 3 ☐ Pro	bably 4 Unknown
ecc	E C	Completed					autopsy 🔎 prior to co	opsy findings available ompletion of cause of
la!			25. Was case referred to medical		20	1□Y	performed? death? 'es 2 □No 1 □ Yes	2 □No
Ξ	Physician: r this certific ral director, I	o Be	examiner?	fospital: 1 ☐ Inpatient 2 ☐ ER/0	Othor	Place of Death (Check of Death	Residence 6 ☐ Other (Speci	ify)
0 0	iding Physin. The After this of tuneral directions.	L:uo	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year) 28b.	. Time of lnjury at Work?		ribe how injury occurred	
isio	Attend death ctor: ,	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home,	M	28f. Locati	ion (Street and Number or Rui	al Route Number,
5	s after s after al Dire	Certification: To	4 ☐ Homicide determined	building, etc. (Specify)		City o	r Town, State)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical (29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Exami	sician: To the best of my knowled ner: On the basis of examination a and manner stated.	ge, death occurred at the time, d and/or investigation, in my opinio	late and place, and due to on, death occurred at the t	o the cause(s) and manner as time, date and place, and due	stated. to the cause(s)
	Fo the vithin 2 to the comple	Med	29b. Signature and title of certifie		29c. License nur		29d. Date signed (Month)	Day, Year)
			1 Jan	sholens mb	2002	3322	10.21.	2609.
	į		30. Name and address of person who co S. S Sachdev	mpleted cause of death (Item 23a			MD21921.	
	Sta	ite	31. Date filed (Month, Day, Year)	mpleted cause of death (Item 23a M D 126 A, B 32. Registrar's Signature	0707,	بروم	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	Registr	ar	OCT 2 1 2	009 Persons d	1 backer			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Min (Month, Day, 06/21/ 1 M 2 217-22-7473 Poland Director 1917 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland the Medical Examiner must be notified at 10d, Inside City Limits Director MD Anne Arundel Annapolis 1 🔀 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 21403 193 Hilltop lane USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: White 3 Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Friedlander Rose Maslow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20902 1121 University Blvd W. # 805 Silver Spring, MD Jason P. Rosenblatt Son 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kneseth Israel Cem. 10/16/2009 Annapolis,MD 12 Ridgely Ave 21. Signature of Junera 22. Name and Address of Facility Hardesty Funeral Home P.A. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory as shock, or heart failure. List only one cause on a chiline. Interval Between Immediate Cause (Final Onset and Just Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine 4 or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events ď Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death been signed by the sales should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy death? certificate 2 No 1 Yes 2 No 1 🗆 Yes 25. Was case referred to me director, Be 26. Place of Death (Check only one) examiner? မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner Death 28a. Date of injury (Month, Day, Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 only one) **Perffying Nurse Bractioner** To the best of my knowledge eath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month) 30. Name and address of person

State

Registrar

31. Date filed (Month, Day,

16

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23 per phys. G899 1/5/10 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3:30 pm Gloria Ann Steffel 16, October 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery 8. Date of Birth (Month, Day, Year 09 / 10 / 1935 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Min. Months Days Hours washington. 74 217-42-3414 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Eventual rules be notified at 1 ☐ Yes 2 X No Director Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6121 Montrose Road 20852 U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No within 72 hours after 1 X Never Married 2 ☐ Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 🗶 No Specify. þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Technician Blood Bank 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel D. Steffel Mary Krucoff 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jerome Steffel - Brother Lakeview Circle, Palmyra, Virginia 22963 permit. Pages 1 a
Department of Her
Important: If Item
any injury or othe 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lebanon Cemetery | 10/18/2009 | Adelphi, Maryland 4 Donation 5 □ Other (Specify), 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 21. Signature of Tuner I Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the die se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. Immediate Cause (Fin Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Arteriosclerotic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) 68760, attending physician for use as the buria certificate be Physician/Medical IF FEMALE Box If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐No Ö 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ś 2 No 3 Probably 4 Unknown Record 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autops, performed No cert ficate 1 ☐ Yes 2 ☐ No 1 □ Yes Vital e Hospital or Attending Physician: 24 hours after death.
8 Funeral Director: After this certificaletely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To o 28a. Date of Injury (Month, Day, Year) 27. Manney of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated the the To the within 7 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier lei nin wa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 121 Day, Year Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 - State Registra AMEND#26perMD, 10-21-09, EMV, McCo Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Year 2009 SILVER **Physician** BEATRICE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Vantage House Nursing Home Columbia If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 5 Social Security Number Days **Funeral** Months Hours 1 ☐ M 2 🗷 F November 16,1918 New York 098-01-8858 Director 90 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County f show r 28a-f show notified at 1 ☐ Yes 2 X No Director Columbia Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō the Medical Examiner must be U.S.A. marked other than "natural", or items 23a 21044 5400 Vantage Point Road death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Specify: þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fii f Health and Mental H tem 27 is marked otl Be Ida Gusoff Harry Shapiro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14070 Stevens Valley Court, Glenwood, Maryland 21738 Rick Silver - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 a 20a, Method of Disposition permit. Pages
Department of
Important: If it
any Injury or or ţ 1 ■ Burial 2 Cremation 3 Removal from State Adelphi, Maryland 4 Donation 5 Other (Specify) Mt. Lebanon Cemetery 10/13/2009 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) **Physician** NEUNDAIA /Medical Due to (or as a consequence of): Examiner TROKE Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Thknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 1□ Yes 21 the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? After (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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21 2009 Registrar

29b. Signature and title of contifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENNETH GEH, and

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

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376(ficate g phys	/edi			d													
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 C	pregnant months?	23c. If yes, out 1 Live 4 Preq	Birth 2	Peta	death 3	Ectopic		у				23d. Dat Mor	e of delive	•	ear
B	requires that the de been signed by the s should be detached	hysi	9 Unknown	J No	g 🗌 Unkr					,cc,ry/								
P. O.	s that gned k	ρ	Part II. Other signif	icant condition	ons contributing to d	eath bu	t not resu	ulting in the	underlying	cause giv	en in Part	I.	23e. Did	tobacco	use contri	bute to the	cause of de	ath2
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Ö	law re has be e 2 sh	nple											24a. Was	psy	р	24b. Were autopsy findings available prior to completion of cause of		
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/ital	sician; The law r certificate has b lirector, page 2 s	Be	25. Was case referre examiner? 1 ☐ Yes 2 ☐	No medical	Hospital:					Othe	ar.		only one)					-
of \	g Phy er this eral d	e: To	27. Mann of Death	1	28a. Date	of injury	/ T	ER/Outpatie 28b. Time o		8c. Injury	at		me 5 Resi 28d. Describe					
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ivisi	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 🗆 Could determ	ined 28e. Place		y - At hor (Specify)	me, farm, st	eet, factory	, office			28f. Location (City or To			r or Rural I	Route Numbe	ır,
	lospita 4 hours uneral ed fillec	Medical	29a. Certifier 1 (Check 2	Certifying	Physician: To the b	est of m	ny knowle	edge, death	occured at	the time,	date and	place, and	d due to the ca	ause(s) a	and manne	r as stated	se/s) and man	ner stated
	thin 2, the F	Ψe	only one) 3 29b. Signature and t	□ Certifying	Nurse Practioner:	To the b	est of my	knowledge,	death occur	red at the	time, date	e and plac	e, and due to the	ne cause	e(s) and ma	nner as sta	ed.	nor oracou.
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			30. Name and addre	ess of person	who completed caus	e of dea	ath (Item	23a) (Type	Print)		<u>U</u> 2	-0		01-	1 0	001		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g897 11-6-09 vt. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Spirlet Gilbert B. 10:50 PМ October 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 5€A 1 🖁 M 2 🗌 F Months Days Hours 88 0270271921 **Director** Massachusetts Usual Residence of Decedent items 23a or 28a-f show 10b. County 10a. State filed within 72 hours after death with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director MD Prince George's Bowie ¹XXYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3616 Mabank Lane 20715 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces?

1 1 2 Yes 2 No
If Yes, Give
Year or Dates. 1942-46 Black, White, etc. "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 XWidowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 4 Cryptologist N.S.A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Leopold Spirlet Dora Louise Maynard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gilbert B. Spirlet, Jr./Son 12413 Salem Lane, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Dopation 5 Other (Specify) Bayview Crematory 10/15/2009 Baltimore, Maryland 21. Signatur of Fineral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or q polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) o the Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv 1 ☐ Yes 2 ☐ No Yes 2 \ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 흔 2 🗆 No Other: 1 ← Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending ieral Director: A filled in by the fu 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a **o the Funeral C** completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month), Day, Year) .. IN 5×1 who completed cause of death (Item 23a) (Type) Print) 3 0 31. Date filed (Month, Da) Registrar's Signature State 9

Registrar

Examiner Division or Vital Records, P.O. Box 68760,

be executed burial-tran attending physician the for signed b page 2 s Physiclan: funeral director. After this e Hospital or Attending 24 hours after death Funeral Director: filled in by

Physician /Medical

Examiner

Funeral

Director

iral", or items 23a or 28a-f show Examiner must be notified at

filed within 72 hours after death Hygiene.

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permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: if item 27 is marked other the any fulury or other traumatic event, the angles.

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Baltimore, Maryland 21215-0036

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Director 11450 Asbury Circle, Apt. Funeral 1 Never Married 2 Married þ 3 ☐ Widowed 4 ☐ Divorced Completed Elementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle, Last) Be David T. Sprague 19a. Informant's Name/Relationship (Type. Print) Thomas Sprague, Brother 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions Examiner if cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 25. Was case referred to medical examiner? Be 1 Tes 25 No Certification: To 27. Manner of Death 1/Natural 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Frederick, MD 32. Registrates Signature Mart awunth 31. Date filed (Month, Day, Year) State Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 35360 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Tomas Jose Solano 12:40 A.M October 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince Georges Laurel 8. Date of Birth (Month, Day, Aug. 27, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1934 1 ☑ M 2 □ F Months Days Hours Min. 577-58-8648 75 Aug. Colombia Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Examirar must be notified at MD Montgomery Silver Spring Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14309 Ansted Road 20905 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 1 X Yes 2 No If Yes, Give 1968-1970 Year or Dates: 1 Never Married 2X Married 1 □ Yes 2 □ No Specify: Colombian altimore, Maryland 21215-0036 ⋧ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) **5+** and Mental Hygiene. Elementary/Secondary (0-12) Medical Physician 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Tomas Solano Carmen Higuera ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10120 Little Pond Place #5
Montgomery Village, MD 20886 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau
once. Monica Solano/Daughter 20b. Place of Disposition (Name of Geo. Wash). United State October Medical center 2009 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Washington, D.C. 4X Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice 22. Name and Address of FacilityColumbia Mortuary Services, P.A. /M00969 > Ceda 9013 Annapolis Rd., Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute on Chronic Renal Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner b. Acute Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (cr as a consequence of). Examine or Attending Physician; The law requires that the death certificate be executed and the burial-tra Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) detached 1 ∏Yes 2 ∏No 9 Unknown 9 Unknown s been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 🗆 No 1 □ Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 Nnpatient 2 ER/Outpatient 3 DOA After this Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No the f 2 Accident Director; 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D55861 October 17, 2009 7300 Van Dusen Road Laurel, MD 20707 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abdul Munim, M.D. 31. Date filed (Month, Day, State OCT 2 1 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35361 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 1425 25, 2009 October James Edward Sherrard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett County Memorial Hospital 0akland Garrett 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 XM 2 □ F 79 May 6, 1930 Pennsylvania Director 291-26-9389 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventual be notified an once. 1 ☐ Yes 2 X No Director MD Garrett Accident 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21520 United States 321 Sale Barn Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Aerospace 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Joseph Sherrard Sarah Jane Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21520 Lois Sherrard, Wife 321 Sale Barn Rd., Accident, MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cumberland Crematory 10/26/09 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550 Katherine 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Gequentially flat curuntures, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. signed by the a d be detached f 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 Probably 4 Unknown icate has been siç ; page 2 should b 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy certificate 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To funeral 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D15333 25/ 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) d Johnson, 311 N Fourth Street, Oakland, MD 21550 Thomas G. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 27 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 22, 2009 **Physician** Henry Sylvester Spiker 10:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Egle Nursing and Rehab Center Lonaconing Allegany If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 212-24-1731 Maryland Director September 27, 1927 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Eventine is ust to neithed at 1 ☐ Yes 2 No Director Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19616 Dan's Rock Road **USA** 21532 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No IYes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tire Builder Rubber 12 permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item 27 Is marked other th any Injury or other traumatic event, ITI ODCE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Lorenzo Spiker Blanche Gertrude McKenzie ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Lee Spiker - Wife 19616 Dan's Rock Road, Frostburg, Maryland, 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition October 23 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, Maryland **Cumberland Crematory** 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. Julelm 8 East Main Street Lonaconing, MD 21539 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) METASTATIC /Medical Due to (or as a consequence of): Examiner UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the a 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed cate has been ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ◯XNo 24a. Was an autopsy performed? yes 2 No After this certificate 1 ☐ Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Lirector. After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 000 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled n by the funeral 27. Manner of De th 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 126907 MD 928 Biemphakh Road Cumbertona Maryland 21502 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2009 35363 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 14, 2009 **Physician** Emma E. Schmersal 11:10 p.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Emmitsburg St. Catherine's Nursing Home Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 € F 110-32-9231 94 Yrs. April 8, 1915 New York Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ul Hygiene. . citier then "natural", or iteme 23a or 28a-f ehow vent, the Medical Examinar must be notified at 1⊈Yes 2 No Maryland Frederick Emmitsburg Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 115 E. Main Street 21727 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: white þ Specify: 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Docent Museum 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Bradley Edwards Marie Zherne 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Franklin Schmersal 115 E. Main Street, Emmitsburg, Maryland item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 TCremation 3 ☐ Removal from State Stauffer Crematory 10-16-2009 Frederick, Maryland 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Stauffer Funeral Home 21702 acmille 1621 Opossumtown Pike, Frederick, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician udSTa9 2 manTh /Medical Due to (or as a consequence of): Examiner OTOLARY a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sicien and e burial-transit 100 resulting in death) Last Lue to for as a consequence of): Completed by Physician/Medical the use as attending for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 No 2 KNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1/X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Cartifier

Division of Vital Records, Attending Physician: within 24 hours after death.

To the Funeral Director: All completely filled in by the fur ō To the Hospital

The law requires that the death certificate be executed

peed

certificate

O. Box 68760,

۵.

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

KREW

32. Registrar's Signature

29c. License number

29d. Date signed (Month. Dav. Year)

9-08239 arbara Ann Sta	ndis	Please Type or Print in Black Indelible In State of Maryland / Department or	nk. Ensure All Copies Ar f Health and Mental Hygier	r <mark>e Legibl</mark> ne		0 0500
	F	1- For State Certificate o	f Death	Reg. No).	9 3536 Time of Death
Physicia Medical Examir		1. Decedent's Name (First, Middle, Last) Barbara Ann Standish	Mor		Year	1435 hrs
		4a. Facility Name (if not institution, give street and number) 23664 Mervel Dean Road	4b. City, Town, or Location of Death Hollywood	1	St. Mary's	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8. D.	ate of Birth(MN	M/DD/YYYY) 9. Birthp Foreign	
Director		220-08-6586 1_M 2XF 39 Yn	Months Days Hours Min.	2/27/19	69 Count	^{ry)} Virginia
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	tion			Od. Inside City Limits
daryland 28a-f show 1 at once	to	Maryland St. Mary's Mechanicsv	111e	100.0	itizen of What Country	Yes 2 X No
death with the Maryland or items 23a or 28a-f shomust be notified at once	Director	10e. Street and Number	20659		ited State	
h with t	Funeral	A F====0	as Decedent of Hispanic Ongin? (Specify N Yes, specify Cuban, Mexican, Puerto Rican,	es or No-	14. Race - America White, etc.	
ter deat, ", or ite		1 X Never Married 2 Married 1 Yes 2 X No 1 3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 X No specify:		Specify: Whit	e
nours af	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decede during grade completed)	nt's Usual Occupation (Give kind of work do nost of working life. DO NOT use retired)	one 16b	. Kind of Business/Ind	ustry
136 Thin 72 le. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 4 General	al Nurse Ass <u>istant</u>	_N	ursing	
15-0036 filed within 7 Hygiene. d other than , th. M. dies		17. Father's Name (First, Middle, Last)	18.Mother's Name (First	, Middle, Maide		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Midical Examiner must be notified at once	To Be	John L. Standish, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	Phv11is J. ng Address (Street and Number or Rural F	Clark Route Number,	City or Town, State	(ip Code)
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati		Phyllis J. Buckler/Mother 41799	New Market Turner position (Name of cemetery, Date	Road, N		ille, MD
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		1 Burial 2 X Cremation 3 Removal from State crematory or or		2000 01	arlotto U	o 1.1 MD
Baltimo permit. Pages Department o Important: injury or oth			Name and Address of Epplify		uneral Hom	
		Edward N. Brinsfield, Jr. M00052 23a. Part I. Enter the disease, or complications that caused the death. Do not enter	2955 Hollywood Road.	Leona	rdtown. MD	20650 Approximate Interval
Physician /Medical	8 0	failure. List only one cause on each line. Immediate Cause (Final disease a. <u>Hypertensive atherc</u>				Between Onset and Death
(caminer		or condition resulting in death) Due to (or as a consequence of):				
	iner	if any, leading to immediate Due to (or as a consequence of):				
si.	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			N.	
executed ian and ial - transit	<u>6</u>	MUNPENDED AMENDED 23.2 DII 27 DAY	mE, g898 12/10/09 T	т Т		
760, icate be physic the burn	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth	o []=	T	23d. Date of delivery Month Da	av Year
X 68 th certif	ician	past 12 months? 1	Sther (Specify)			,
). Bo the dea by the a	Phys	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	ne cause of death?
s, P.C iires that i signed d be deta	ed by	Obesity			2 No 3 Proba	
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be ex After this certificate has been signed by the attending physician tuneral director, page 2 should be detached for use as the burnal	Completed			24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
Rec n: The tiffcate or, page			26.Place of Death (Check only o	Yes 2_ one)	No 1 ✔ Yes	2 No
Vita hysician this cer	To Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie			sidence 6 Other:	Scene
			of Injury 28c. Injury at Work? 28d.	. Describe now	injury occurred	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Function: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st	reet, factory, office building, etc. 28f.	Location (Stre		al Route Number, City
E Hospital 24 hours a e Funeral etely filled			curred at the time, date and place, and due	to the cause(s	and manner as state	d.
To the Hos within 24 h To the Fun completely	Medical	one) 2 ✓ Medical Examiner:On the basis of examination and/or investi	gation, in my opinion, death occurred at the	time, date and	d place, and due to the	e cause(s)
	Ž	29h Signature and tiple of permitter	29c. License number O.C.M.E.		9d. Date signed <i>(Mon</i> October 24, 2009	
		30. Name and address of person who completed cause of death (Item 23a)				
		20 Deficient	Penn Street, Baltimore, MD 212	201 		
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Luis			

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 0223A M Evelyn Hall Tarr /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Peninsula Regional Medical Center Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number -6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Yea 4/3/1922 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛣 F Months Days Hours Min. 87 Maryland Director 215-62-0436 Usual Residence of Decedent iled within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County show 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be neutified at Director 1 ☐ Yes 2X No MD Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2031 Colona Road 21851 USA Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 XNo Specify <u>م</u> Specify: 3 Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Hairdresser Cosmotology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fil h and Mental H ' is marked otl ပ္ Samuel F. Hall Minnie Mariner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sh ment of Health an ant; If item 27 is 1 2065 Colona Rd., Pocomoke City, MD 21851 Elaine Herz (daughter) item 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date ₩ 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Important; If any injury o 4 ☐ Donation 5 ☐ Other (Specify) First Baptist Cemetery 10/21/2009 Pocomoke City, MD 22. Name and Address of Facility
Holloway Funeral Home, Professional Association
107 Vine St., Pocomoke City, MD 21851 21. Signature of Funeral Service Licensee lin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any. leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trai Due to (or as a consequence of): P.O. Box 68760, the attending physician Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐Yes 2 Z No 9 Unknown 9 Unknowr Part II, Pther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 After this certificate 1 □ Yes 2 1 No 2 No 1 □Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 60515 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 614 STERN SHURE OR, SALISBURY MD21804 HIMMAN ET3 Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 0 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** DUMAN + M 0 300 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 5550 Gloucester Street Churchton Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 12 M 2 □ F 216-22-1413 Director 82 7/4/1927 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Maryland Anne Arundel Churchton 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5550 Gloucester Street 20733 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: δ Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ira Joseph Toleman Sr. Blanche Beatrice Tolley ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Toleman - Daughter 1615 Bright Star Way NE, Olympia, WA 98506 20b. Place of Disposition (Name of cemetery, crematory or other place) 10/19/2009 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home Nydin T. Klobert 147 Duke of Gloucester St, Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗌 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes → ₩o 24a. Was an autopsy 1 □Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

31. Date filed (Month, Day, Year) OCT 16 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Bestyck Rd Sale 300 Annyolis MD 2140 32. Registrar's Signature

29c. License number

29d. Date signed, (Month, Day, Year)

3003

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 For State Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 7:20 PM LINDA ANNE BEALL UTZ OCTOBER 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 111 KIRWAN'S LANDING LANE CHESTER QUEEN ANNE'S 8. Date of Birth (Month, Day, Year)
NOV. 26, 1940 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Months Days Hours 68 220-38-1861 MARYLAND Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Exeminer must be nutified at 1 ☐ Yes 2 ▼No Director MARYLAND **OUEEN ANNE'S** CHESTER 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 111 KIRWAN'S LANDING LANE 21619 UNITED STATES Funeral or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iten any Injury or other traumatic event, Its Madical Event Inspec. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INSURANCE AGENT INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ERNEST BEALL ပ္ BEATRICE COLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELVIN LEE UTZ, SR./HUSBAND 111 KIRWAN'S LANDING LANE, CHESTER, MARYLAND 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) OCTOBER 23 UNION CEMETERY BURTONSVILLE, MARYLAND 2009 21. Signature of Funeral Service License Address of Facility
HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** nelas /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Daw to for as a bunsequence of Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No the 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 🗌 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an has autopsy performed

1 Yes 2 No certificate 25. Was case referred edical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To nours after death.

neral Director: After this filled in by the funeral di this 28a. Date of Injury (Month, Day, Year) 27. Manne Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide within 24 hours a
To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO Jarri 31. Date filed (Month, Day, Year) Registrar's Signature State 21 Registrar

Saltimore, Maryland 21215-0036

the Hospital or Attending Physiclan: The law requires that the death certificate be executed neral Director: After the filled in by the funeral 24 hours a

27. Manner of Death

1 Natural

3 Suicide

29a. Certifier

Medical

2 Accident

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

5 Pending investigation

6 □ Could not be

٥ dRW State

26358 OCT. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRED FRICK, WEIGEZ 31. Date filed (Month, Day, Year) 32. Registra s Signature 2 0 2009 Registrar knews

Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

the

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day, Year)

and manner stated.

	,		For State		-		artment of H		nd M		200	0	3536	. 0
			1 = State Registra AMEND#23b, 23d 1. Decedent's Name (First, Middle,	e, 25, 27perMC	0,10/21/	09,BMW9,	rtificate of	Death ———		Re 2. Date of Death	g. N ₂ 0 0	7		
	Physici	an			a					Month Oct.	Day \	Year	3. Time of Dea	atn M
	/Medio		April T. 4a. Facility Name (If not institution,				4b. City, Town, or	r Location of		JC L -	02 200 4c. County of		18:00	
	LAGIIII	ici	Washington Ad	lventist	Hosp:	ital	Takoma	Park			Montgo	omer	У	
	Funeral			6. Sex 7 1 □ M 2 🗓 F	. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day,	Year)	Count	ace (State or Fo	reign
	Director		577-82-0287 Usual Residence of Decedent	1	46	Yrs.			(05/19/6	53	DC		
	yland now		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10	d. Inside City Li	mits
	a-f st	ctor	MD Monto	omery	В	urton	sville						Yes 2]No
	or 28	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of Wh	at Count	ry?	
	s 23a		3738 Berleigh			0 140	20866		1.0.10		JSA			
	within 72 hours after death with the Marylan ane. than "natural", or items 23a or 28a-f show a Madical Everting must be notified at	Funeral	11. Marital Status 1 Never Married 2 ☐ Marrie	12. Was Decedo Armed Force d 1 ☐ Yes 2	es?	.S. 13. \	Was Decedent of H If Yes, specify Cuba	an, Mexican,	Puerto P	lican, etc.)		White, et	c.	
5-0036	al",o		3 Widowed 4 Divorced	If Yes, Give Year or Date			1 □Yes 2 💢No	Specify:			Specify:	3lac	k	
ر م	72 ho 'natur	Completed by	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece	dent's Usual Occup kind of work done of DO NOT use retired	ation during most o	of workin	1	6b. Kind of Busi	ness/Indi	ustry	
7	within ene. than'	ldm	Elementary/Secondary (0-12)	College (1-4	or 5+)				·)	. T.	du a+ ~=	
7 0	filed v Hygid other	ပိ	17. Father's Name (First, Middle, La	ast) Unknov	wn	Admii	nistrati		's Name	(First, Middle, M	Private aiden Surname)		austry	
yland	lid be lental ked c	To Be		Ollitio	W 11			Delo	res	Lorett	a Warf	fiel	d	
Mary	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Eventual must be notified at		19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street	and Number	or Rural	Route Number,	City or Town, S	tate, Zip (^{Code)} 2.0.8.6	6
و, ≥	and 2 ealth n 27 i		Garnell Wood/	Son		3/38	Berleig	Jn Hi	11 (it. Bur	tonsvi	гтте	, MD	
0	ges 1 If Itel or oth		20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 3	☐ Removal from St			sition (Name of natory or other place		Da		0c. Location - Ci	-		
altimor	it. Pa irtmer irtant: njury		4 □ Donation 5 □ Other (Spe		Ri		le Park	11(0/13	/09 Ri	lverdal	.e,M	D	
g	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic enone.		21. Signature of Funeral Service Lie		CC0278	0 2	2. Name and Addres	ss of Facility	Latr	ney's E	uneral	- Ho	me,Inc	
			23a. Part 1. Enter the disease, or co shock, or heart failure. List or	omplications that cau	sed the deat		831 Geor er the mode of dyin						ZUUII Approximate Interval Between	n
1	Physician		Immediate Cause (Final disease or condition	lly one cause on eac	50	DOS	1.0					1	Onset and Deat	ń
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):								
	LXammer	7	Sequentially list conditions,	b. — Duo to (o	as a conseq	uanca off:						_		
)	uted I Insit	mine	if any, leading to immediate cause. Enter Under in Cause (Disease or injury that initiated events	Due to (or	as a consequ	uence or):								
-	exection and and ial-tra	Examiner	resulting in death) Last	c Due to (or	as a consequ	uence of):								_
2/00	ficate be executed physician and s the burial-transit	dical		d										
Š	ertifica ling ph e as th	Med	IF FEMALE:											
Š	eath o attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?		me of pregna th 2 ☐ Feta nt at time of c	Ideath 3 □	Ectopic pregnanc	у			23d. Date Monti		y Day Year	
5	the de	iysic	1 ☐Yes 2 ☐ No 9 🗷 Unknown	9 ☐ Unknow		eath 5 L	Other (specify) _						•	
7.	ned by deta	y Ph	Part II. Other significant condition	s contributing to deat	th but not resu	ulting in the ur	nderlying cause give	en in Part I.		23e. Did toba	acco use contrib	ute to the	cause of death	1?
coras,	quires	ed by								1 ☐ Yes	3 2 □ No 3	☐ Proba	bly 4 Unkn	iown
ည ည	law re as bec 2 sho	Completed								24a. Was an	24b. We	ere autop	sy findings avail	lable
ב	The The page	E O								autopsy perform 1 2 Yes 2	ed? de:	ath? ⊒Yes 2		; 01
la N	clan: sertific sctor,	Be (25. Was case referred to medical examiner?	119-1					of Death	(Check only one)			
5	Physical din	٦.	1 ☐ Yes 2 📉 No 27. Manner of Death	Hospital: 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		ER/Outpatien 28b. Time of		4 LI Nurs		e 5 Resider			1	
5	ding th. After funer	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month,	Day, Year)	Injury	Work	yat (? Yes 2∐No		3d. Describe hov	v injury occurred			
2	Atten r deal ector: by the	ifica	3 Suicide 6 Could not		Injury - At ho	me, farm, stre	eet, factory, office			3f. Location (Stre	eet and Number	or Rural	Route Number,	
5	tal or rs afte al Dir	Certification: To	4 ☐ Homicide determine	building	, etc. (Specin	у)				City or Town,	State)			
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 ☐ CertifyIng (Check only one)	Physician: To the be aminer: On the bas and manner	is of examina	wledge, death tion and/or in	n occurred at the tir vestigation, in my o	ne, date and pinion, death	l place, a n occurre	nd due to the ca d at the time, da	use(s) and man te and place, <i>a</i> n	ner as sta d due to	ated. the cause(s)	
	To the within To the comple	Mec	29b. Signature and title of certifier	71		MD	29c. License	e number		29	d. Date signed (Month, D	ay, Year)	
	ν		20 Name and add -	#601			II-G	0166	2		10-01	5 -6	7	
			30. Name and address of person where \$31 / Univ	ussulf 1	3100	Ea 16	Silva	1 tm	~ rt	16 A	JMES			
	Sta Registra	te ar	31. Date filed (Month, Day, Year) OCT 2 1 2	009 32/Reg	istrar's Signa	ture Same	Med.							
				- July toru	- 1	- Comment								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 35370 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 1000 Merkel Lovelle Walters 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs.

Adonthe Days Hours Min. Wicomico Peninsula Regional Medical Center 8. Date of Birth (Month, Day, Year) March 10,1930 9. Birthplace (State or Foreign Country) Texas Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 79 465-34-6957 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Modeal Examinar must be notified at 1 ☐ Yes 2 No Director Rhodesdale Maryland | Dorchester the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? hours after death with USA 5737 Eldorado Road 21659 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify. Specify: White ρ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. 10 Hospital Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked. any Injury or other traumatic ev Millie Anne Bleeker Albert Dewitt Walters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5737 Eldorado Road, Rhodesdale, Maryland 21659 Lori Lee Robinson/Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State MD Veterans Cemetery | 10/21/2009 Beulah, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 Signature of Funeral Service Lice , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 11. Enter the disease, or conshock, or heart failure. Immediate Cause (Final disease or condition resulting in death) CAD **Physician** /Medical Due to (or as a consequence of): Examiner ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an autopsy performed? 1 □ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificate 2 🗆 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🛂 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA မ this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? After or Attending Natural 2 Accident 5 Pending investigation To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐No death. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Sean 17/09 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAlisbury Md. 21801 BABULAL 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yea 13,2009 Physician Month OCTOBER 2:05P M ELIZABETH LEE WHEELER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 9. Birthplace (State or Foreign Country)
Maryland 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🗓 F Months Days Hours 96 May 5, 1913 Director 215-26-8440 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, it is Medical Evariation in the profiled at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 No Director Maryland Frederick Brunswick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 802 North 5th Ave. 21716 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify White Specify: 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Moler Pearl Shewbridge ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2806 Fox Hound Road, Ellicott City, MD 21042 Duane Smith / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Harper Cemetery 10/17/2009 Harpers Ferry, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa Stauffer Funeral Home ne of Funeral Service Licenses 22. Name and Address of Facility 1100 North Maple Ave., Brunswick, MD 21716 23a Part 1. Enter the disease, or complication, the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tenure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYJUARDIA 2 days **Physician** disease or condition resulting in death) ACUTE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical To the Hospital or Attending Phystcian: The law requires that the death certific within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lew Mil 22037 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 610 Bounvick 2/7/6 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Mae Wimbrow 10/16/2009 Lotta 2:35 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harrison Senior Living Snow Hill Worcester Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year, 9/13/1913 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days Hours 1 M 2 F Virginia 96 Director <u>218-14-4203</u> Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be redified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 □Yes 2 No MD Worcester Stockton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 741 Greenbackville Road Funeral 21864 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No <u>ک</u> Yes Give Specify 3 X Widowed 4 ☐ Divorced Specify: Year or Dates white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Clothing Manufacturing 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) John Pruitt Pearl Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madeline Lankford (daughter) 741 Greenbackville Rd., Stockton, MD 21864 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pag Department Important: I any injury o 4 ☐ Donation 5 ☐ Other (Specify) Portersville Cemetery 10/20/2009 Stockton, Maryland 21. Signature of Funeral Service Licensee Holloway Funeral Home, Professional Association 107 Vine St., Pocomoke City, MD 21851 un 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence or): Physician: The law requires that the death certificate be executed burial-transit physician and s the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical attending IF FEMALE: for use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.0. 1 ☐ Yes 2 □ No the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐Yes 2 ☐No 1 ☐ Yes this certific al director, i 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral of 27. Manner of Death 28a. Date of Injury Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation (Month, Day, Year) 1 Natural safter decral Director; Att 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) **0CT 2 0 2009**

Vink

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32. Registrar's Signatur

A. park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Q934 W Charles Louis Younkin, Sr. 10 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death County of Death mber last Allegany WMHS- Braddock Campus Hrs. 8. Date of Birth (Month, Day, If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 **X** M 2 □ F Yrs 1957 52 Pennsylvania 212-76-4244 May 16, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Grantsville Garrett 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 575 Platter Rd. 21536 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔼 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shipping Clerk Textiles 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hilda Platter Willis Younkin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 575 Platter Rd., Grantsville, MD Denise L. Younkin/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. 29, 2009 Grantsville, MD Laughlin Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. Signa ure of Filuneral Service Licenses oZi P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriosclerotic heart disease disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 XNo 1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ SR/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

The law requires that the death certificate be executed physician and the burial-transit Box 68760, attending pl P.0 After this certificate has been signed by the funeral director, page 2 should be detached Division of Vital Records, Physician; al or Attending F neral Director A

Physician

/Medical

Director

Funeral

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Completed

Be ပ

Examiner

Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, It a Medical Experient must be notified at

Department of Health ar Important: if item 27 is any Injury or other trau

Physician

/Medical

Examiner

Physician/Medical ≥ Completed Be Certification: To

Medical

State

Registrar

Examine

29a. Certifier

(Check only

25. Was case referred to medical 27. Manner of Death

3 ☐ Suicide 4 ☐ Homicide

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated.

29b. Signature and title of certifier

29c. License number D09157

29d. Date signed (Month, Dav. Year)

Oct 26 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Snow, M.D. 31. Date filed (Month, Day, Year) OCT 29 2009

Dpty Med Ex

124 W3rd ST Cumberland

DHMH 17 Rev 1/2001

Hospital 24 hours a

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			For State Registrar	State o	of Marylan		artment of F ctificate of a		nd Mental Hy			
			Decedent's Name (First, Mide	dle, Last)			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2. Date of D			33 Time of Death
1	Physici /Medic		Salome Naomi Y						Octobe	per 24, 2009 1:		1:40 PM
Ì	Examir	ier`	4a. Facility Name (If not instituti Goodwill Menno		umber)		4b. City, Town, o		Death		County of Death	
	Funeral		5. Social Security Number 220–52–9981	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs.	V==	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, D	lay, Year)	Cour	
i.	Director		Usual Residence of Decedent		95	110.			Jan. 3	3, 19	l4 Mich	igan
	arylan show dat	-	10a. State 10b. Count	,		y, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2 🔀 No
	the Ma 28a-f	recto	MD Garre 10e. Street and Number	tt	Gr	antsvi	11e			10a Citiz	en of What Cour	
	h with 23a or st be	al Di	1188 Dorsey Ho	tel Rd.			21536	5		USA		,.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☒ Widowed 4 □ Divorce	12. Was Dec Armed F rried 1 Yes	2 X No ive		Was Decedent of H f Yes, specity Cuba I ☐ Yes 2X No	lispanic Originan, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)		4. Race - Americ Black, White, Specify:	
2-0	72 hot 'natura dical E	eted	15. Decede (Specify only high	nt's Education est grade completed))	16a. Deced	lent's Usual Occup kind of work done o OO NOT use retired	ation during most o	f working	16b. Kin	d of Business/Ind	
21215-0036	within iene. than the Me	Completed	Elementary/Secondary (0-12)	College ((1-4or 5+)	Homem		d)	3	Owr	n Home	
	al Hyg J other	Be C	17. Father's Name (First, Middle	e, Last)				18. Mother's	Name (First, Middle			
Maryland	d Ment d Ment narked natic e	2	John Bontrager 19a. Informant's Name/Relation			405-14-11		Mary E				
Ma	nd 2 sl alth an 27 is r r traur		Joseph M. Yode						or Rural Route Numi Rd., Grant			21536
Baltimore,	les 1 and 2 of Health a of item 27 is		20a. Method of Disposition 1 X Burial 2 □ Cremation	3 □Removal from	20b. F	Place of Disponentery, crem	sition (Name of natory or other place	ce)	Date	20c. Loc	cation - City or To	own, State
ij	t. Pag rtment rtant: I		4 □ Donation 5 □ Other (Specify)					t. 28, 20			
Bal	permi Depar Impor any Ir		21. Signature of Funeral Service	- Meu	male	P		275, Gr	Newman E cantsville	, MD	al Homes 21536	, P.A.
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Examiner 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of):							arrest,		Approximate Interval Between Onset and Death			
8760,	ficate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	that initiated events C.								
.O. Box 6	t the death certi by the attending ached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							23d. Date of delivery Month Day		
Records, P.	w requires that been signed be should be det	٥	Part II. Other significant condi	ions contributing to o	death but not res	ulting in the ur	nderlying cause give	en in Part I.			/	ne cause of death?
al Reco		Completed							24a. Was auto perf 1 Yes	s an opsy ormed? 2 No	prior to cor death?	psy findings available mpletion of cause of
Vita	nystcian: Th iis certificate director, pag	o Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2 □	ER/Outpatien	t 3 DOA Othe		Death (Check only			
Division or	ding Pt	ation: To	27. Manner of Death 1 Natural 5 Pend 2 Accident inves	28a. Date ng (Mor ligation		28b. Time of Injury	28c. Injur Worl		ng Home 5 ☐ Res 28d. Describe			y)
Divis	그 글 달 ㄷ	Certification:	3 Suicide 6 Could 4 Homicide deter	mined 200. Flace	e of injury - At ho ling, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location City or To	(Street and own, State)	Number or Rura	I Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical (29a. Certifier 1 Certify (Check only one) 1 Medica	ing Physician: To the I Examiner: On the b and mar	e best of my kno basis of examina oner stated.	wledge, death tion and/or inv	occurred at the tir restigation, in my o	ne, date and popinion, death	place, and due to the occurred at the time	e cause(s) a	and manner as si place, and due to	tated. o the cause(s)
	To the within To the Complex	ž	29b. Signature and title of certific	er. 1	6	0	29c. License	e number 34z	>21		signed (Month,	
7		-	30. Name and address of perso	n who completed cau	se of death (Item	1 23a) (Type, I		272	-31	Octob	per 25,	2009
			Robin Bissell,				ville, MI	2153	36			
	Sta Registr	_	31. Date filed (Month, Day, Year OCT 2 1		Registrar's Signa	d.	and I					

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009	35376
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	1- For State Registrar	Certificate of Death	Re	2009 35.	3/1
Physician/ edical Examine	Decedent's Name (First, Middle,Last)		2. Date of Death Month October 30		th
euicai Examinei	James Atkins 4a. Facility Name (if not institution, give street and number)) 4b. City, Town, o	October 30	0, 2009 2030 Hrs	
	633 N. Aisguith Street Apt. 3A	Baltimore			
Funeral Director	215 14 9678 _{1 XM 2 F}	ge (In yrs. last birthday) 8 5 Yrs. If Under 1 Yes Months Day	ar If Under 24Hrs. 8. Date of Birt 04 Apr. 2	h(MM/DD/YYYYY) 9. Birthplace (State or Foreign CountryMD	r
any	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location		10d. Inside City	y Limits
and show nee.	MD n/a	Baltimore		1 X Yes 2	No
h the Maryland 3a or 28a-f show any otified at once. I Director	10e. Street and Number 633 N. Aisquith St.	10f. Zip Code 21	202	g. Citizen of What Country? USA	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland men of Health and Mental Hygiene. To their traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 X Never Married 2 Married Armed Forces 1 X Yes 2 3 Widowed 4 Divorced If Yes, Give Year 9	? If Yes, specify Cuba	spanic Origin? (Specify Yes or Non, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Blac White, etc. SpecifBlack	ck,
ours afte	15. Decedent's Education (Specify only highest grade cor	mpleted) 16a. Decedent's Usual Occupa	ation (Give kind of work done	16b. Kind of Business/Industry	
5-0036 ed within 72 hours tygiene. other than "natu the Medical Exan	Elementary/Secondary (0-12) College (1-4 or 1 2 t h	during most of working life laborer		Self Employed	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	17. Father's Name (First, Middle, Last) John Atkins		18.Mother's Name (First, Middle, M Susie Allen		
ID 21 2 should and Me 27 is ma matic ev	19a. Informant's Name/Relationship (Type, Print) Joseph A. Atkins (son		et and Number or Rural Route Num er Ct. Balto, l		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 'Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical To Be Compile.	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from St	20b. Place of Disposition (Name of ce	emetery, Date	20c. Location - City or Town, State 19 Baltimore, Md	
Baltim permit. Pa Departmen Important injury or or	4 Donation 5 Other Specify: 21 Inature of Funeral Service Licensee	i i	s of Facility • Scruggs Fund Preston St. B		
Physician	23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do not enter the mode of dying	Preston St. Ba , such as cardiac or respiratory arre	alto, Md. 21213 st, shock, or heart Approximate Between Ons	
/Medical Examiner		Cardiovascular Disease equence of):		Death	
ner	Sequentially list conditions, if any, leading to immediate Due to (or as a constance. Enter Underlying Cause	equence of):			
ted d ansit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a cons	equence of):			
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68760, ertificate be ding physici e as the buri	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcomed the best of the be	2 Fetal death 3	Ectopic pregnancy	23d. Date of delivery Month Day Ye	ear
that the death certificate by the attending detached for use as by Physician	1 Yes 2 No 9 Unknown 9 Unknown	time of death 5 Other (Specify)			
- x 50 v _	Part II. Other significant conditions contributing to deat	h but not resulting in the underlying cause		bacco use contribute to the cause of dea 2 No 3 Probably 4 Vunk	
Records, The law requires ficate has been sig , page 2 should be Completed			24a. Was a autops perfori	sy prior to completion of cau	
	25. Was case referred to medical	26 Plac			No
Vital ysician his cert directo	examiner?	ent 2 ER/Outpatient 3 DOA	Inthor: 5	Residence 6 🗸 Other: Scene	
- L - L - L	27. Manner of Death 1 ✓ Natural 5 Pending	(ear)	ury at Work? 28d. Describe h	ow injury occurred	
Division o septral or Attending hours after death. meral Director: Afte y filled in by the fune Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined (Specify)	njury - At home, farm, street, factory, office	building, etc. 28f. Location (S or Town, St	treet and Number or Rural Route Number ate)	er, City
To the Hospital within 24 hours a To the Funeral completely filled	29a. Certifier 1 Certifying Physician: To the best of m	ny knowledge, death occurred at the time, o imination and/or investigation, in my opinio			
Ne Fred	29b. Signature and title of certifier	29c. Licen:		29d. Date signed (Month, Day, Year)	
	aller		M.E.	November 3, 2009	
	30. Name and address of person who completed cause of a Zabiullah Ali, M.D. Assistant Medical E		timore, MD 21201		
State Registral	A - 0000	ar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:25 AM 03 2009 Jean Elizabeth Benedict /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Towson Edenwald Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Hours Days 1 □ M 2 🛛 F 10/24/1915 Pennsylvania 94 212-62-5964 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedeal Examinating the countries of the contract 1 ☐ Yes 2X No Director Churchville Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with U.S.A. 21028 2502 Lady Anne Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 Specify White Completed by 3 XWidowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaking 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental I Pages 1 and 2 should be Laura Elma Stanley Amoss Wilson Cook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a tem 27 is 2502 Lady Anne Court - Churchville, Maryland 21028 Susan L. Nelson (daughter) 20c. Location - City or 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11/06/2009 Timonium, Maryland Dulaney Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 8) 11750 Belair Road - Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Stare disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physlcian: The law requires that the death certificate be executed Due to (or as a consequence of): sician a burial-1 Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as 1 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 pronths? 1 □ Yes 2 Z No 9 □ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy page 2 performed? Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director. Be Other: Hospital: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation ours after death.

neral Director: #
filled in by the fu 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medical The destroying rings loan. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completely fi 3 INCRNI 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie GNP-BC R154032 Schen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Rd. Towson, no 21286

DHMH 17 Rev 1/2001

State

Registrar

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NOV 04

31. Date filed (Month, Day, Year)

Susan

Souther

800

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PI line a-b, 25, per MF g897 11/18/09 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 21, 2009 **Physician** October William . Levein Brown 9:00 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9727 Mt. Pisgah Rd. #411 Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 √ M 2 □ F Months Days Hours Min. Yrs 025-12-8223 85 March 16,1924 Director Massachusetts Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exa. I'm. That be neather a once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 □ Yes 2√□ No MD Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9727 Mt. Pisgah Rd. #411 20903 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married XYes 2 Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Black þ Specify: res, Give Year or Dates: 1943–46 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Postal Worker US Postal Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Brown Ruby Levein ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Digovich / Daughter 2917 Simkins Ct., Palo Alto, CA 94303 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran Cem. 10/30/2009 Cheltenham, MD 22. Name and Address of Facility
Rapp Funeral and Cremation Services
933 Gist Ave., Silver Spring, MD 21. Signature of Pyrjeral M00382 20910 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical onsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HAPPROVED BY MEDICAL EXAMINER Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): CERTIFICAT physician a Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. 1 ☐Yes 2 ☐No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate I 1∐Yes 2 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1X Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural
Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner to state.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

4 2009

1941

leted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			1 - For State Registrar	State of Ma	ryland /		irtment of I <i>tificate of</i>	Health and M <i>Death</i>	, ,	giene Reg. No.2 () ()	9 35379
	Physic /Med		Decedent's Name (First, Middle, La Marvin Jos	*	ordelo	n			2. Date of Dea Novembe	ith	3. Time of Death
•	Exami Funera	ner	11905 Oden Ct. 5. Social Security Number 6. 8	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 15 Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birth							eath SOMETY Birthplace (State or Foreign Country)
	Director		435-30-8531 Usual Residence of Decedent 10a. State 10b. County		86 10c. City, Tov	Yrs.			Sept.	18,1923 I	ouisianna 10d. Inside City Limits
	th the Mary or 28a-f shu	Director	MD Montgo	omery		R	ockville		1	10g. Citizen of What	1 □Yes XXX No
	ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Madical Exp. inher must be notified at	by Funeral Director	11905 Oden Ct. 11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ender Armed Forces? 1 ☐ Yes 2 ☑ Note of Yes, Give Year or Dates:	ver in U.S.			1852 Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)		nerican Indian,
	Baltimore, Maryland 21215-0036 sermit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Madical Expansione.	eted	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation)	(Give F life. D	ent's Usual Occup kind of work done O NOT use retire ultant	during most of worki	ing	16b. Kind of Busines	
	Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other traumatic event, Item any Injury or other traumatic event, Item any Once.	To Be C	17. Father's Name (First, Middle, Last Russell	Borde				18. Mother's Name	an	Maiden Surname) Dupuis	
	e, Mar 1 and 2 sh Health and em 27 is m ther traum		19a. Informant's Name/Relationship (Barbara Bordelo	" . ′	1	1905	Oden Ct	., Rockvi	11e, MD	r, City or Town, State	
	Itimor nit. Pages artment of ortant: If ite Injury or o		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Service Light)	(y)	Unifo	rmed	ition (Name of atory or other place	s Univ.	1/03/ 2009	20c. Location - City of Bethesd	a, MD
D. W.	Derm Deem any end		to A La	man		9	33 Gist	Ave., Silv	ver Spri	n Services ing, MD 2	0910
21.15	Physician Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line	te Myo	card	ial Infa		or respiratory arr	est,	Approximate Interval Between Onset and Death Minutes
109 mg	68760, continued infinitely that the following physician and the burial-transit in the following the	al Examiner	Sequentially list conditions, if any kenting to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):						Decades Decades	
Dod	Box eath cer attendin for use	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	Fetal deatl		Ectopic pregnanc Other (specify)	у		23d. Date of d Month	elivery Day Year
	cords, P.O. w requires that the d s been signed by the should be detached	ed by P	Part II. Other significant conditions of	ontributing to death but	not resulting i	in the und	derlying cause giv	en in Part I.			to the cause of death? Probably 4 🔲 Unknown
Borbelon	of Vital Records, Physician: The law requires the this certificate has been signeral director, page 2 should be or		25. Was cope referred to medical		-11				24a. Was an autops perform	y prior to ned? death? 2∭No 1 □ Ye	autopsy findings available o completion of cause of es 2 \sumbox No
		ition: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day,	2 ER/O	utpatient Time of Injury	28c. Injur Work	4 Li Nursing Hor	me 5 XX Reside	e) ence 6 ∐Other <i>(Sp</i> ew injury occurred	pecify)
MARVEN	Division ital or Attending irs after death. ral Director: Afte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	(Specify)		f et, factory, office	2	City or Town		
\$	the Hosp thin 24 hou the Funer mpletely fil	Medical	one)	ysician: To the best of niner: On the basis of e and manner state	xamınatıon ar	e, death nd/or inve	estigation, in my o	pinion, death occurre	ed at the time, da	ate and place, and du	ue to the cause(s)
	5 × 5 × 5		29b. Signature and title of pertifier	O. Yeary	m	/T = -		0279/ 992DC	ŀ	November	
- -	10		30. Name and address of person who or Daniel Young M.D. 31. Date filed (Month, Day, Year)		nnectio			#104, Wash	nington	D.C. 200	15
	Sta Registr		NOV 0 4 2009	De la la la la la la la la la la la la la		Back	0				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year HERBERT **BLOCK** 29, October 0 2009 10:10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 01/29/1948 Birthplace (State or Foreign Country) 1 X M 2 □ F Months Days Hours Min. 216-52-7309 61 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 ☐ Yes 2√☐ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2105 SUGARCONE ROAD 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INVESTMENT INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **AARON BLOCK** GERTRUDE EISBRUCH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUTH BLOCK / WIFE 2105 SUGARCONE ROAD BALTIMORE, MD 21209 20b. Place of Disposition (Name of Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MOSES MONTEFIORE 11/01/2009 BALTIMORE, MD Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that c used the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition Onset and Death al fuse colar disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Month Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2. No 1 □Yes 2 No 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No 1 npatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

"natural", or

7 Is marked other traumatic event.

permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra

Director

Completed by Funeral

Be

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and burial-trar attending physician for use as the buria signed by the a

page 2 should has certificate

Division of Vital Records, P.O. Box 68760公

The

Examine Physician/Medical þ Completed e Hospital or Attending Physician: 24 hours after death, e Funeral Director: After this certifical letely filled in by the funeral director, t Be ၉ Certification: Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Tes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only

the within 7

> State Registrar

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 () () 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Year Branagan Jane 30 2009 11:35 A M October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2219 CORALTHORN ROAD MIDDLE RIVER BALTIMORE 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Months Days Hours Min MARYLAND 214-22-3039 Yrs. 84 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 □Yes X□No MD BALTIMORE MIDDLE RIVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2219 CORALTHORN ROAD 21220 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2X No Specify. Completed by Specify: 3€Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5 HOUSEWIFE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH VIENNA CASTINA ဥ MARY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTINA SMITH/ DAUGHTER 2219 CORALTHORN ROAD, MIDDLE RIVER, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial A ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 11/4/09 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee LILLY Address EILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Atheroscientic Cardiovascular Disease disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a sunsequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mog Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐Yes 2 ☐No 1 □Yes 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify)

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and

permit. Pages Department of Important: If it any Injury or o

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, it is Maritical Examinar must be notified at

Baltimore, Maryland 21215-0036

the burial-trai attending physician for use as the buria **Director:** After this certific

signed by the

has

this certificate

Division of Vital Records, P.O. Box 68760

Physician/Medical ģ Completed Be Certification: To

25. was case referre to	o medical
examiner?	
1 ☐ Yes 2 ☐ No	
07 Moment of Doroth	

Manuer of Death 1 V Natural 2 Accident

6 Could not be determined 4 Homicide

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

Reisterstown, MD. 21136

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

3 ☐ Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

200

29b. Signature and title of certifier Kajapalise M.D 29c. License number B0057465 29d. Date signed (Month, Day, Year) 10/31/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIS-Rajapakse, MID 25 Mainsty Suite

31. Date filed (Month, Day 4 2009

32. Registrar's Signature

Registrar

completely filled in by

Medical

within 24 hours a

To the Funeral I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35382 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CREIBHTON Month ERTHA CORINA 5:15 PM DCTOBER 200 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Jown, or Location of Death 4c. County of Death Altimore JUSEPH RICHEY Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗷 F Months Days Hours Min (Month, Day, 217-22-8438 86 Director 923 MARYL DETOBER 10,1 Usual Residence of Decedent show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director other traumatic event, the Medical Examiner must be notified 28a-f MARYLAND BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 21239 STONEWOOD J. SA or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify. "natural" Specify: BIACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) GRADE MANIAG SOMEN'S CLOTHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ WILLIAM CARTER LAURA BANKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health sem 27 INGRAM (DAUGHTER) STONEL RD., BALTIMORE, MD 21239 DOOC Greghten 1925(9) item 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State Page 1 1 🗷 Burial 2 🗌 Cremation 3 🗀 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST CEM 11/03/2009 DWINGS MILLS, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 22. Name and Address of Facility 305EPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD 21217 illiam 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ EXSANCUINAMON disease or condition resulting in death) 30 M/N Medical Due to (or as a consequence of): Examiner ZEAST CAN YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): death certificate be executed and-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-t Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month 4 ☐ Pregnant. 9 ☐ Unknown ed by the a detached f g Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 😿 No 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 ☐ Yes 2 🗷 No 1 Yes director, 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. Accident 1 🗌 Yes 2 🗌 No Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the bases of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) the 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** October 30, Alan C. Campbell 2009 9:40 amM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brook Farms Court Perry Hall Baltimore County If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 4. Camptry) 1 and 5. Social Security Number **Funeral** Days Hours January 19,1934 1 XM 2 □ F Director 213-30-1962 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shore Examiner must be notified at Perry Hall Director 1 ☐ Yes 2 No Balto. Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21128 7 Brook Farm Ct. Unit E Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ∭No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 ☐ XNo ģ Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Circuit Court Balto. City Deputy Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be fi Department of Health and Mental I-Important: If Item 27 is marked ot any Injury or other traumatic ever Pages 1 and 2 should be nent of Health and Mental Schooler Edna Vincent D. Campbell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Campbell Spouse 7 Brook Farm Ct. Unit E Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Moreland Memorial 11-2-2009 Parkville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licensee 9705 Belair Road Nottingham, Maryland 21236 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of using, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause to reach line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Le to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by of Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 □Other (Specify) Certification: To r of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 1 Matural 5 Pending investigation neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral 11 Ceptifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 I tedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one)

State Registrar 29b. Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Fegistrar's Signature

park

29c. License number

0030149

29d. Date signed (Month, Day, Year)

			_ State	State of Maryland				Mental Hy	giene Reg. No.20	00	35384
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of L	Jeain ————————————————————————————————————	2. Date of De		0 9	3. Time of Death
	Physic /Medi		Thomas	Ricker	Cal:	lery		October	28° 20	0 9 ear	10:20p •M
	Exami	ner	4a. Facility Name (If not institution, give sti	,		4b. City, Town, or			4c. Count		
	Funeral	_	Maplewood Park Plac 5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	Bethesda	If Under 24 Hrs.	8. Date of Bir (Month, Da		gomer	y place (State or Foreign
	Director		094-07-0976 Usual Residence of Decedent	1 2 F 100	Yrs.	Months Days	Hours Min.	Jan. 2	2, Year) 2, 1909	NJ Couin	itry)
	yland Jow		10a. State 10b. County	10c. City	, Town or Loc	ation				11	0d. Inside City Limits
	e Mar 3a-fsk	ctor	MD Montgomer	y Beth	nesda						1 ☐ Yes 2本 No
	th with th	Funeral Director	10e. Street and Number 9707 Old Georgetown	Road		10f. Zip Code 20814			10g. Citizen of USA	What Coun	itry?
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modern Exprintment must be notified at once.	þ	11. Marital Status 12 1 □ Never Married 2 □ Married 3 ₺ Widowed 4 □ Divorced	Was Decedent Ever in U.S Armed Forces? 1₩Yes 2☐No If Yes, Give Year or Dates: WWII		as Decedent of His Yes, specify Cubar □Yes 2√∏√No	spanic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Ra Bla Specii	ce - Americ ck, White, e	
15-	n 72 h "natu	lete	15. Decedent's Educa (Specify only highest grade of	ion ompleted)	16a. Decede	ent's Usual Occupa ind of work done di O NOT use retired)	tion uring most of work	ing	16b. Kind of B	usiness/Ind	Justry
212	withir liene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		NOT use retired) Execut			Pharma	acenti	ical
Þ	e filed al Hyg other vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,			- Car
yaı	Menta Menta arked atic er	To	Thomas Aloysius Cal	Lery			Margare	t Ricker	r		
Baltimore, Maryland 21215-0036	and 2 sho salth and n 27 is m er traum		19a. Informant's Name/Relationship (Type T. Grant Callery, se	Print) On	19b. Mailing 7907 C	Address (Street a uster Rd	nd Number or Rur • Betheso	al Route Number la, MD	er, City or Town 20814	State, Zip	Code)
ore	ges 1 at of He If item		20a. Method of Disposition 1 ☐ Burial 2 ♣ Cremation 3 ☐ Ren	loval from State		itory or other place) ;	Date	20c. Location	•	,
Ħ.	it. Pa irtmen rtant; njury		4 ☐ Donation 5 ☐ Other (Specify)	Che MO15	_	e Cremato			Beltsvi		
Ba	Depa Impo any ir		21. Signature of Funeral Service Libensee			Name and Address 3 Gist A					ion Svcs. 910
			23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one	ions that caused the death. cause on each line.	Do not enter	the mode of dying	, such as cardiac	or respiratory a	rest,		Approximate Interval Between
0	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Respiratory		re					Onset and Death
	Examiner		ſ	Due to (or as a conseque Pneumonia	ence of):						
	pe și	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):						
Mag.	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque							
68760,	tificate be executed g physician and as the burial-transit	edical E	d	Due to (or as a conseque	siice oi).						
		Medi	IF FEMALE:			****					
P.O. Box	Attending Physician: The law requires that the death cert refeath. refoath. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3 🗆 E	Ectopic pregnancy Other <i>(specify)</i>				te of deliver	ry Day Y ear
S,	ss that gned k	by P	Part II. Other significant conditions contrib	uting to death but not result	ting in the und	erlying cause giver	in Part I,	23e. Did to	bacco use cont	ribute to the	e cause of death?
ord	w requires to been signer should be a							1 □ Y	es 2√2 No	3☐ Proba	ably 4 Unknown
Division of Vital Records,	The law cate has b	Completed						24a. Was a autop perfor 1 ☐ Yes	sv	Were autop prior to com death? 1 □Yes 2	osy findings available npletion of cause of
Vita	vsician: Th	Be	25. Was case referred to medical examiner?				26. Place of Death				
of	Phys	P.	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatient 2 ☐ E	R/Outpatient		4 th Ivursing Ho)
on	nding tth. :: Afte e fune	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	28c. Injury a Work?	at es 2 □ No	28d. Describe h	ow injury occurr	ed	
Divis	I or Atter after des Director	Certification: To	3 🗆 Suicide 6 🗆 Could not be	8e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stree			28f. Location (S City or Tow	treet and Numb n, State)	er or Rural	Route Number,
_	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one) (Check only one)	an: To the best of my knowl On the basis of examination	ledge, death o	occurred at the time stigation, in my opi	e, date and place, nion, death occurr	and due to the ded at the time, d	cause(s) and madate and place,	anner as sta	ated. the cause(s)
	To the Compile	Me	29b. Signature and title of certifier			29c. License	number	2	29d. Date signe	(Month, D	ay, Year)
			I merlyn Ve	muy All	1	D 35	5791		10/30/2	009	
	6t1		30. Name and address of person who comp Merlyn K. Veury, MD;	eted cause of death (Item 2	23a) (Type, Pri	nt)		D 20902			
	Stat Registra	е	31. Date filed (Month, Day, Year) NOV 0 4 2009	32. Registrar's Signatur							
	negistra		MUY UZ ZOOJ /	and B. He	RAGRE						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Dennis W. Cornish State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day October 30, 2009 Medical Examiner Dennis W. Cornish 0201 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital **Baltimore** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In yrs. last birthday) Days Foreian Director Months Hours Min 219 94 8288 Country MD x M 2 F 30 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits items 23a or 28a-f show 1 Yes 2 No MD n/a Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1525 Edmondson Ave. 21228 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 X Never Married 2 Married White, etc. Yes Widowed Divorce If Yes. Give Year Yes 2 X No specify: Specify: Black þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Improvement Antonio'sManagement llth 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Dennis W. Cornish, Sr. Be Terra A. Weatherbee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2121 3rd Flr.) Terra A. Cornish (mother) Fulton Ave. Balto, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Burial 2 Cremation 3 crematory or other place) King Mem.Pk. Nov.5,2009 Balto.Co, MD Donation 5 Other Specify: nature of Funeral Service Licenses 22. Name and Address of Facility Calvin B. Scruggs 1412 E. Preston S Funeral Home Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical a. Stab Wound of Chest Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last ned by the attending physician and detached for use as the burial - transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 1 V Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 Other 4 ER/Outpatient 3 Nursing Home 5 Residence 6 Other: ۵ 1 V Yes After t 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject stabbed Natural FOUND: within 24 hours after death.

To the Funeral Director: completely filled in by the fi 5 Pending Yes 2 ✔ No Oct 30, 2009 0122 hrs 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Found, 1600 Blk Edmonson Ave, Baltimore, MD (Specify) Found, Local Street 4 V Homicide 29a. Certifier 1 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 30, 2009 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Carol Allan, MD 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 **OCME 2006**

State

Registra

NOV 0 4

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 4a-b, per MD, & 10b, per Fh 9897 11/4/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day HARRIET 5:30 A OCTOBER CHAIT 30. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Reisterstown FUTURE CARE HOMEWOOD BALTIMORE 5. Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Year) 1 □ M 2 🕱 F Hours 219-16-8489 84 Director 03-20-1925 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It & Medical Exertilised at 10b. County Carroll 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 🛛 No BALTIMORE FINKSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2150 BROWN ROAD Completed by Funeral 21048 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **PROPRIETOR** CLEANING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL SODDEN ANNE ပ္ ELY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STACY GILLIS/DAUGHTER 2150 BROWN ROAD. FINKSBURG, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place ANSHE EMUNAH AITZ 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11-01-2009 | BALTIMORE, MD 5 ☐ Other (Specify) CHAIM 22. Name and Address of Facility SOL LEVINSON & BROTHERS, Signature of Funeral Service Lickness INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death bo not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions 🦍g to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has 2 S er this certificate has eral director, page 2 autopsy 1 ☐Yes 2 ☑No 25. Was case referred to dical examiner? 26. Place Death (Check only one) 1 ☐ Yes Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 🗖 Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manual of Death 1 Matural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 29b. Signature and title of certi 30. Name and len 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV - 4DHMH 17 Rev 1/2001

ORIGINAL

09-08397
Rena Dixon

Rena Dixon	State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death Reg. No. 2009 3538
Physician/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Anoth Day Voc
Medical Examine	RENA DIXON October 29, 2009
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Maryland General Hospital 4c. County of Death Baltimore
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) if Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Director	Usual Residence of Decedent
v any	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
Maryland 28a-f show datonce.	MARYLAND N/A BALTIMORE 1 No. 1 Yes 2 No. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
215-0036 be filed within 72 hours after death with the Maryland null Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once. Be Completed by Funeral Director	
with the same noti	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
death or item	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.
s after rral", or niner	3 Widowed 4 Divorced of Yes, Give Year 1 Yes 2 No specify: Specify: Specify: BURCK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
11215-0036 Id be filed within 72 hours after dental Hygiene. narked other than "natural", event, the Medical Examiner o Be Completed by I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+)
036 ithin 7 ne. r than ledica	12 TH CRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
15-0 liled w Hygie dothe the M	
Z = 2 = 3 0	
	LEON DIXON (BROTHER) 57/17 UTRECHT RD., BALTIMORE, MD 2/306 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
	assembles of ethor place)
Baltimore, Pernit. Pages I ar Department of He Important: If ite	4 Donation 5 Other Specify: MT. ZION CEMETERY 11/04/2009 LANSDOWNE, MARYLAND
Baltimo permit. Page Department o Important: injury or oth	21. Signature of Funeral Service Licensee 22. Name and Address of Facility 30 28 PH H. BROWN JR. FUNERAL HOME 30 28 PH H. BROWN JR. FUNERAL HOME 3140 N. FULTON AVE., BALTIMORE, MD 21217
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a Methadone intoxication and cocaine use Death
`xaminer	or condition resulting in death) Due to (or as a consequence of):
5	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
ed nsit Examiner	(Disease or injury that initiated Avents continued by the
uted nd ransit	events resulting in death) Last Due to (or as a consequence or): d.
68760, certificate be executed certificate by sician and nding physician and essas the burial - transit essa the burial - transit essa the burial - transit essa the burial - transit essa the burial - transit essa the burial - transit essa the burial - transit essa the burial essa the burial essa the essa than essa	X UNPENDED 23a,27,28a-f,perm,E g897 11/23/09 TT
68760, certificate be nding physici se as the buri	IF FEMALE: 23b. Was decedent pregnant in the 23b. Was decedent pregnant in the 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
OX 6876 ath certificate attending phy or use as the sician/M	past 12 months? 4 Pregnant at time of death 5 Other (Specify)
). Box the death compared by the attentiched for us	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
P.O. es that the igned by be detacled by F.O.	1 Yes 2 No 3 Probably 4 V Unknown
Division of Vital Records, P tal or Attending Physician: The law requires to after death. al Director: After this certificate has been sign led in by the funeral director, page 2 should be reffication: To Be Completed to	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
eco he law ate has age 2 s	
n of Vital Rec ling Physician: The After this certificate funeral director, page on: To Be Con	25. Was case referred to medical 26. Place of Death (Check only one)
f Vit	1 V Yes 2 No Impatient 2 ER/Outpatient 3 DUA 4 Nursing Home 5 Residence 6 Utiler:
on or ading the control of the contr	
Division pital or Attent ours after death eral Director: filled in by the Certificati	Accident Investigation Investigation Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 446 Cummings Ct
Division ospital or Attending rours after death. neral Director: After filled in by the fune Certification:	Suicide 6 X Could not be determined (Specify) house or Town, State) 446 Cummings Ct Baltimore, MD
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u Medical Certification: To Be Completed by Physic	
F % F % D	
	Pameth Jouthall, MD O.C.M.E. October 30, 2009
	30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature
Registra	NOV O 1 COST / MARCH /
DHMH 17 Rev 1/2001	ORIGINAL

			For State Registrar	State of Maryland / D	epartment of F Certificate of			ene . No. 2009	35388
	Physici		Decedent's Name (First, Middle, Last, Doreen Demaris Dilla				Date of Death Month Oct.	Day Year 31 2009	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give Seasons Hospice	· · · · · · · · · · · · · · · · · · ·	Randall:			4c. County of Death Baltimore	
	Funeral Director		215-90-8203	7	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) 11-8-1965	(ear) 9. Birth	place (State or Foreign ntry)
	aryland show	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town				1	10d. Inside City Limits 1 □ Wes 2 □ No
	with the N 3a or 28a-	Funeral Director	MD n/a 10e. Street and Number 4108 Glenhunt Road	Balt	imore 10f. Zip Code 212	29	100	g. Citizen of What Cour USA	ntry?
36	be filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Exartieur must be notified at		11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cub: 1 ☐ Yes 2√ No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Afri	
21215-0036	ithin 72 hou ne. han "natura Involce E	Completed by	15. Decedent's Edu (Specify only highest grad	cation 16a.	Decedent's Usual Occup (Give kind of work done life, DO NOT use retire Dject Manager	durina most of workir	ng	bb. Kind of Business/In	
	be de ev	Be	17. Father's Name (First, Middle, Last)	<i>э</i> т ПС	Ject Parager	18. Mother's Name	(First, Middle, Ma		
Maryland	nd 2 should lith and Mer 27 Is marke r traumatic	유	Gordon Dillard Jr. 19a. Informant's Name/Relationship (7) Darlene Dameron/ Siste		Mailing Address (Street 406 Sudbrook R	and Number or Rura	l Route Number, (p Code)
Baltimore,	permit. Pages 1 and 2 Department of Health. Important: If Item 27 I any injury or other tra once.		20a. Method of Disposition 1 Burial 2 A Cremation 3 F 4 Donation 5 Other (Specify)	20b. Place of cemetery	Disposition (Name of crematory or other place crematory		ate 20	oc. Location - City or To altimore, MD	own, State
Balti	permit. Depart Import any inj		21. Signature of Funeral Service Licens	. Wyki		ess of Facility Wyli y Road, Rand		Hame P.A. of MD 21133	Balto. Co.
	Physician	1	23a. Part 1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)		ot enter the mode of dyin		r respiratory arres	it,	Approximate Interval Between Onset and Death
0,	rate be executed Examiner physician and the burial-transit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of	n:				
O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pre∮nant in the past 12 gronths? 1 □ Yes 2 □ No 9 □ Unknown	d	су		23d. Date of deliv Month	ery Day Year	
rds, P.	quires that en signed b uld be deta	þ	Part II. Other significant conditions co	ntributing to death but not resulting in	the underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to t	
Il Records,	The law requir cate has been s page 2 should	Completed				· · ·	24a. Was an autopsy performe	prior to co death?	opsy findings available ompletion of cause of
of Vital	Physician: The rule certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out 28a. Date of Injury 28b. T	patient 3 D DOA		(Check only one) me 5 ☐ Residen 28d. Describe how	ce 6 Other (Speci	atient hopile
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ш	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co		sician: To the best of my knowledge, ner: On the basis of examination and and manner stated.					
	To the within 2 To the comple	Me	29b. Signature and title of certifier N S Ruj a parse	MID	29c. Licens	DC7465		d. Date signed (Month,	
			30. Name and address of person who co	ompleted cause of death (Item 23a) (Type, Print)	eisterstown	n, MD. 2	21136	
	Sta Regista		31. Date filed (Month, Day, Year)	2009 ^{32. Registrar's Signature}	. parts				

09-08040 John R. Edney

The property of the property	n R. Edney		State of Maryland / Department of Health and Mental Hygiene -For State Certificate of Death Reg. No. 2009	3538
TRUCKED DISCOSI TO WINDOW SERVING ROAD 2.13 - 6.8 - 8.15.2		an/	tegistrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death April Day Year	
Common Control Contr	Julius = /18		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	,
The control of the			213-68-8152 53 Months Days Hours Min. 00/10/1056 Foreign	
The proof of the	id how any ce.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10	d. Inside City Limits Yes 2 No
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Physician The state of the sta	5 a 6 a 5	ToB	19a. Informant's Name/Relationship (Type, Print) Amber Edney/Daughter 19b. Mailing Address (Street and Number or Rural Foute Number, City or Town, State, Zi P.O. Box 7194 Duluth, MN 55807	
Physician Medical aminor Page Pa	imore, Pages and ment of Heal tant: If iten or other tra		1 Burial 2 Cremation 3 Removal from State Crematory or other place) Oct. 28, Beltsvill	e MD
The final property of the cause of the activity of the cause of the activity of the cause of the activity of the cause of the activity of the cause of the activity of the cause of the activity of the activi		_	21. Signature of Funeral Service Licensee 87.17 Green Pastures Dr. Balto. 23a. Part lienter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	Approximate Interval
The first fi	/Medical	0.0	Immediate Cause (Final disease a. HEROIN INTOXICATION	
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The state of the s	se es crar	≗	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	Voor
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29b. Signature and ture of depititer O.C.M.E. October 17, 2009 30. Name and address/of person who completed cause of death (Item 23a)	Vital F hysician: 7 this certific	Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 ✓ Other: 5	Scene
29b. Signature and ture of depititer O.C.M.E. October 17, 2009 30. Name and address/of person who completed cause of death (Item 23a)	Sion of Attending F death. ector: After by the funer		1 Natural 5 Pending found at 10:03 AM 1 Yes 2XX No UNKNOWN	al Route Number, City
29b. Signature and ture of depititer O.C.M.E. October 17, 2009 30. Name and address/of person who completed cause of death (Item 23a)	Divi Hospital or 4 hours after Funeral Dir		3 Suicide 6XX Could not be determined (Specify) FOUND IN WOODS 500 WILLOW SPRING 4 Homicide 29a. Certifier 4 Contituing Physician To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and marrier as stated.	ROAD,
OCME 30. Name and address of person who completed cause of death (Item 23a)		Medica	29b. Signature and title of legifier 29c. License number 29d. Date signed (Month	th, Day, Year)
I I I A DE FORM DE L'OLLERS DE L'OLLERS DE L'AND DES L'OLLES DE L'			30. Name and address of person who completed cause of death (Item 23a)	
Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 State Registrar Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201			31. Date filed (Mogth Clay, Year) 2000 32 Registrar's Signatur	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day 2, Physician Gustavo Flores Bonilla Novermber 2009 9:58AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1√2 M 2□ F Yrs. 213-96-3944 79 Director Feb. 5, 1930 Nicaragua Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ---- any injury or other traumatic event. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 21 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4011 Randolph Rd. 20902 Nicaragua Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married XXYes 2□No Specify: Nicaraguan ð Specify: 3 Widowed 4 Divorced Hispanic Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver Transportation 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gustavo **Flores** Bonilla (Unknown) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeannette Fox / Daughter P.O. Box 4. Westby, WI 54667 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State Chesapeake Crematory 11/4/09 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 21. Signature of Funeral Service Licensee M00382 The Dollanam 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Acute Renal Failure weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) burial-transi Hypernatremia days and resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760 certificate be Physician/Medical Severe Obstipation weeks IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ End-stage Alzheimer's Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? <u>Type 2 Diabetes Mellitus</u> 24a. Was an page 2 s this certificate has autopsy performed? Vas 2 2 10 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) upanich form NO D 0065485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Supanich M.D. 1500 Forest Glen Dr., Silver Spring, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2009 Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mary		artment of F rtificate of		1ental Hyg	jiene eg. No.200	35391	
	Physic		1. Decedent's Name (First, Middle, La Marjorie Ann Fran	·				2. Date of Deat Month	Day Yea		
	/Medi Exami		4a. Facility Name (If not institution, given			4b. City, Town, o	r Location of Death	October	31, 2009 4c. County of De		
			26 Ensor Ave.			Co	ckeysville	2	Baltimore County		
	Funeral Director		215-30-8006	Sex 7. Age (In	yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 31	Year) 9. E , 1934 Te	irthplace (State or Foreign Country) Xas, Maryland	
	fand ow		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits	
	a-f sh	ţò	Maryland Baltimo	ore County	Cockeysv	ille				1 □Yes 2 🛱 No	
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What (Country?	
	s 23a	eral	26 Ensor Ave.				21030		United St	ates	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination unstable any once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1		Was Decedent of H fYes, specify Cuba I□Yes 2XINo	ispanic Origin? (Spe an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wh Specify:	nerican Indian, lite, etc. White	
2-0	72 ho	eted	15. Decedent's Ec	ducation	16a. Deced	dent's Usual Occup	ation	00	16b. Kind of Busines	s/Industry	
121	vithin ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L		during most of worki	ng	0 : 1	77 J	
d 2	filed v Hygie other t	ပ္ပ	17. Father's Name (First, Middle, Last)	N/A		Meat Wra	18. Mother's Name	(First Middle A	Giant	FOOG	
<u>la</u> n	fid be fental rked c	To Be	Harold Elwood Rob				Eva Marie				
ary	and M	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street			; City or Town, State	, Zip Code)	
Σ,	and and lealth m 27 l		Mr. Russell A. Pe			Rosanda		Middle	River, Ma	ryland 21093	
lore	iges 1 nt of H if Itel or otl		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3 ☐	nemoval from State	Ob. Place of Dispos cemetery, crem		INO	ate 04,	20c. Location - City of	r Town, State	
턡	iit. Pa artmer ortant: njury		4 ☐ Donation 5 ☐ Other (Specify	y) [[Dulaney V		n• 200	09	Timonium,	Maryland	
Ba	permi Depa Impo any ir		21. Signature of Euperal Service Licer	- Janet	2 Pe 23	aceful A 25 York 1	lternativ Road Ti	es Funer Monium,	al&Cremat Maryland	ion Ctr., P.A 21093	
	Physician /Medical		23a. Part / Enter the disease, or composition of near failure. List only immediate Cause (Final disease or condition resulting in death)	plications that caused the congrause on each line. a					est,	Approximate Interval Between Onset and Death	
	Examiner	<u></u>	Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEACT FAILURE Due to (or as consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of):								
	d d ansit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	COPID	isequence oi).						
90,	ifficate be executed g physician and as the burial-transit	I Exa	resulting in death) Last	Due to (or as a con	sequence of):						
68760,	ficate I physic s the b	edical		d							
. Box	eath cer attendin for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year	
rds, P.	w requires that the d been signed by the should be detached	ρ	Part II. Other significant conditions co	ontributing to death but not	resulting in the und	derlying cause give	n in Part I.	/		to the cause of death?	
l Rec	The la	Completed						24a. Was an autopsy perform	prior to death?	autopsy findings available completion of cause of	
Vital	nding Physician: th. : After this certifical funeral director, p	Be	25. Was case referred to medical examiner?	Hospital:		100	26. Place of Death				
0	this ald	1: To	1 ☐ Yes 2 😿 No 27. Manger of Death	1 ☐ Inpatient 2 28a. Date of Injury	2 ER/Outpatient		4 LI Nursing Hon		nce 6 Other (Sp	ecify)	
<u>.</u>	nding ath. r: Afte e fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Yea	r) Injury	28c. Injury Work	rat ? ′es 2 □ No	8a. Describe nov	w injury occurred		
DIVISION	or the Hospital of Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	at home, farm, stree ecify)	et, factory, office	2	8f. Location (Str. City or Town,	eet and Number or F State)	Rural Route Number,	
	ne nospi in 24 hour he Funer, pletely fill	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
i	With 70 th	Σ	29b. Signature and title of certifier						29d. Date signed (Month, Day, Year)		
			Xellyn				1271		11/2/09		
			30. Name and address of person who c Daniel Collettor,			*					
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's Si	st Padon gnature	la Road	Timoniu	Maryl	aud 210	93	
	Registra	ır	NOV 0 4	2009 Cene	gnature A. A	park					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 State
Registrar 35392 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DOLLY OCTOBER FRIEDMAN 30 2009 10:15 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F 213-26-9915 Months Days 80 0570271929 **Director** MD Usual Residence of Decedent 10a. State 10b. County ural", or items 23a or 28a-f sho I Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MΩ BALTIMORE BALTIMORE 1 ☐ Yes 2 🕅 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1840 REISTERSTOWN ROAD, APT. 227 21208 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. WHITE 3 Nidowed 4 □ Divorced Completed event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) **HOMEMAKER** OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ည MAURICE **GLASSMAN** errit. Page 1 and 2 should be exartment of Health and Men reportant; If item 27 is markeny injury or other traumatic. ANNA DORTCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEVEN FRIEDMAN / SON 10517 ORCHARD VALLEY DR., NORTH POTOMAC, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BETH TFILOH CONG. 11/02/2009 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD permit.
Departn
Importa
any inju 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of uneral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician/ Due to (or as a core ruence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month 9 Unknown 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by advanced dementia, parciconitis 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed Yes 2 1 Yes after death.

Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 XNo Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending Accident Investigation 1 🗌 Yes Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar

To the I within 2 To the I

only one) 29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sigrature

Sutula

31 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35393 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:31 a $_{\rm M}$ Physician/ THERESA ANN FAJARDO October 30. Day 2009 Year Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death **Baltimore** Gilchrist Hospice Ceneter Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Mary Land Director 215-80-0854 47 Usual Residence of Decedent Show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗷 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21046 Apt. 102 985 Clock Fower Lane U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates White 3 Widowed 4 Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Claims Representative Health Insurance Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 2 Ear1 Richard Dorothy Browning Fajardo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1115 South Hanover Street, Baltimore, Maryland 21230 Dorothy Fajardo 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Cedar Hill Cemetery Nov. 04, 2009 Brooklyn Park, Maryland 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licenses 130 East Fort Avenue, Baltimore, Maryland 21230 23a. Pyr. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one is use on each line. Approximate Interval Between Onset and Death me late Cause (Final Physician/ emplicaTONS Medical resulting in death) Due to (or s a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death
Unknown Year been signed by the a should be detached Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Spina bikda 3 Probably 4 Unknown Completed 1 🗌 Yes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autonsy certificate Yes Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) exammer? 1 Yes 은 2 No Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year, 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural Natural 5 Pending injury work? 1 ☐ Yes 2 🗌 No Investigation 6 Could not be Accident s after deat Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State 24 hours a Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier соmpleted (Check

Registrar

State

3 □

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certified

AANON 31. Date filed (Month, Day, Year)

within 2 To the I

THERESA

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

OCTOBER 30 2009

			1 - For State Registrar	State of Maryla	nd / Depa <i>Ce</i>	artment of H	ealth and M Death		eng 009	35394		
	Dhusisi		1. Decedent's Name (First, Middle, L					2. Date of Death Month	Day Year	3. Time of Death		
	Physici /Medio		valerie	Gaskin	5			10_	28 09	1415 M		
	Examir	ier	4a. Facility Name (If not institution, g			-	Location of Death		4c. County of Death	1		
			Northwest has 5. Social Security Number 6.	Sex 7. Age (In vrs	s. last birthday)	If Under 1 Year	((Stown	8. Date of Birth	201+11	mplace (State or Foreign		
	Funeral Director		212-60-4278	1□M 2XF 57	Yrs.	Months Days	Hours Min.	(Month, Day,	Year) Co.	untry) MD		
			Usual Residence of Decedent					03 27	52			
	anylan bhow		10a. State 10b. County		City, Town or Lo					10d. Inside City Limits		
036	Ba-f	Director	MD NA		Balti					12 Yes 2 No		
	with the	Dir	10e. Street and Number	~ t m2		10f. Zip Code	21215	10	g. Citizen of What Co.	•		
	leath	era	4 Russern Ct A	12. Was Decedent Ever in	U.S. 13	Was Decedent of Hi		ocify Yes or No-	14. Race - Ame			
	be filed within 72 hours after death with the Maryland ital Hygiene. of other then "neturel; or items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Amed Forces?		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes X☐ No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, White	e, etc.		
5-0	72 hc	Completed	15. Decedent's (Specify only highest g	Education trade completed)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired,	ation during most of worki	na 1	6b. Kind of Business/I	industry		
121	within iene. then	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired, ail Mana			Clothing	Store		
D 2	e filed v Il Hygie other t	ပိ	11th grade 17. Father's Name (First, Middle, Las	na st)	Rec	all mane	18. Mother's Name			50010		
an	Mental Merked o	To Be	Joseph Gaskin	ıs			Vernell					
ary	2 should be and Mental ie marked (19a. Informant's Name/Relationship	(Type, Print)					City or Town, State, Z			
Σ	o € Γ' ⇒		Tora Snell-Da	ughter	462	4 Belvie	eu Ave,	Baltime	ore, Md 2	21207		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Mer importent: If item 27 ie marke eny Injury or other treumatic once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Control	☐Removal from State	cemetery, crei	sition (Name of natory or other place lawn			Woodlawn			
Balt	permit. Departimport. eny Inj		21. Signa ure of Funeral Service Lic	onson Kel	22 M 4	Name and Address ACC FAR ACC Waba	s of Facility H West ash Ave,	Balti	more, Md	21215		
	Physician /Medical Examiner		23a. Part i Enter the disease, or co shock, or heart failure. List on	mplications that caused the dealy one cause on each line.	ath. Do not ent	er the mode of dying	g, such as cardiac o	r respiratory arre	st,	Approximate Interval Between		
			Immediate Cause (Final disease or condition	. ASCV	D					Onset and Death		
			resulting in death)	Due to (or as a conse	equence of):							
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	nsit	nine	if any, leading to immediate cause. Clifer Underlying Cause (Disease or injury	Duo to (01 as a conse	querice or).							
Ć.	tate be executed thy sician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):							
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9	rtifica ng ph as th	Med	IF FEMALE:			7.0		-	-			
P.O. Box	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the buriat-transit	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fel 4 □ Pregnant at time of 9 □ Unknown	23d. Date of deli Month	23d. Date of delivery Month Day Year						
S, D	s that ned b e deta	y Pł	Part II. Other significant conditions	contributing to death but not re	sulting in the u	ndertying cause give	in in Part I.	23e. Did toba	acco use contribute to	the cause of death?		
ğ	w require been sig should b							1 🗆 Yes	s 2 No 3 Pro	obably 4 Dunknown		
Division of Vital Record	The law re ate has be page 2 sho	Completed						24a. Was an autopsy perform	prior to c	topsy findings available completion of cause of		
Vita	icien: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		10:	26. Place of Death	1				
ō	Phys this ral dir	-T	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2	28b. Time of		4 Nuising noi		nce 6 Other (Spec	elfy)		
- O	Attending r death. ector: After by the funer	Certification:	1 Natural 5 Pending 2 Accident investigate	(Month, Day Year)	Injury	Work	at :? /es 2 □ No	28d. Describe hov	w injury occurred			
Visi	Attendir death.	Ifica	3 Suicide 6 Could not	be 28e. Place of Injury - At I	home, farm, str				eet and Number or Ru	ral Route Number,		
ā	s after of Dire	Cert	building, etc. (Specify) City or Town, State)									
	To the Hospital or Attending Physicien: The law within 24 bours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying F (Check only one) 1 Medical Exa	Physician: To the best of my kn aminer: On the basis of examin and manner stated.	nowledge, death nation and/or in	n occurred at the tim vestigation, in my op	e, date and place, a inion, death occurre	and due to the cau ed at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)		
	To the within 2 To the complet	Σ	29b. Signature and the of certified			29c. License			d. Date signed (Month			
	/		JUN L	- M.D.		Doda	02614		10-30-00	7		
			30. Name and a dress of person who	completed cause of death (Ite	om 23a) (Type,	Print) UV+Roa	of Rand	ells town	10-30-00 MD 2113	3 3		
	Sta Registr		31. Date filed (Month, Day, Year) MOV 0 4 2009	32. Registrar's Sign	South	9						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM# 4cperPHYS, G897, 11710/09, WS

State of Maryland / Department of Health and Mental Hygiene 200 35395 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** (JRIFFIN FON 1.25 A 11 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Lone Hawen Coutonsville Nursing Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours 527-46-898 1**№** M 2□ F 11-27-Director 931 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show Ħ 1 Yes 2 No notified Director timore 28a-f MD 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code Item 27 Is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be I USA 01223 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates:/94 8 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 ₩idowed 4 Divorced lack Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use etired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) rivel (DUNTY 7. Father's Name (First, Middle, Last) Maiden Surhame) 18. Mether's Name (First, Middle, Be Pages 1 and 2 should be 0 ia ပ orse 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1to. MD 21223 Brenda wenue Saltimore, 20b. Place of Disposition (Name of gemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State wines Mills Mi 11-12-09 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Quehn C. Seerne Funeral Services permit. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EREBROVASCULAR THEROSCLEROTIC Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Upknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an cate has t page 2 s autopsy performed certificate DUSPHAGNA Vital 2 No Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes မ 2 No 0 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Medical Certification: Division 5 Pending investigation To the Hospital or Attending Natural Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) alham D 28595 suelle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

MILIME

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32. Registrar's Signature

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-42009

MINEEM

31. Date filed (Month, Day, Year)

NOV

SUITE 283,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 9

			for State Registrar	State of M	arylan	-	artment (<i>tificate</i> (/lental H	ygiene Reg. N	2000	35396
	Physicia		1. Decedent's Name (First, Middle, La	St) GUARNI	EPA					2, Date of D	eath	ay Year	3. Time of Death 9:15 P M
4	Medic Examir		4a. Facility Name (if not institution, giv	e street and number)			4b. City, Tov		on of Death	OCTOBER		c. County of Death	1
	Funeral		JOHNS HOPKINS BAYVII 5. Social Security Number 6.5	Sex 7. Ag		ER ast birthday)	If Under 1 \		der 24 Hrs.	8. Date of B	irth	N/A	hplace (State or Foreign
	Director		218-42-4562 Usual Residence of Decedent	□ M 2 X F	64	Yrs.	Months D	ays Hour	s Min.	AUG.	29°,	1945 MA	ŔŶLAND
	/land f show d at	ţo	10a. State 10b. County		10c, Cit	y, Town or Loc							10d. Inside City Limits
	ne Man or 28a- notifie	Direc	MD N/A			BALT	IMORE				10= 0	Citizen of What Co	1 X Yes 2 No
	n with the	Funeral Director	3017 GIBBONS	AVENUE				21214			10g. C	U.S.A	•
920	hours after death with the Maryland natural", or items 23a or 28a-f sho lical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 🌠 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates.		lf	/as Decedent Yes, specify ☐ Yes 2 🍒	Cuban, Mexi	can, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Amer Black, White Specify: WH	
Maryland 21215-0036	2 2 8	Completed	15. Decedent's l (Specify only highest g	rade completed)		(Give k	ent's Usual O ind of work d NOT use ret	one during n	ost of worki	ng	16b. l	Kind of Business I	ndustry
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land	l be file fental H rked ot tic ever	70 B	17. Father's Name <i>Eirst, Middle, Last)</i> UNKNOWN					18. M	other's Name DORI	e (First, Middle S K	, Maiden REII		
Mary	12 should be fil uth and Mental 27 is marked of r traumatic ev		19a. Informant's Name/Relationship (nber or Rura	l Route Numb	er, City o	r Town, State, Zip	*
	1 and 2 of Healt fitem 2	8	DAVID STALTER/ 20a. Method of Disposition	-	20b. P	Place of Dispos	ition (Name o	of	T	BALT'	_	RE, MD.	21214 Town, State
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or othel once.		1 X Burlal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	fy)		emetery, crem C LAWN	CEME	TERY					,MARYLAND
Bal	permit. Pag Departmen Important; any injury once.		21. Signature of Fundral Service Licen	see		² t 7	ATLLY 00 S.	ddress of Ea CON I	ÎËER KLING	INC.	FUNI	ERAL HO	ME RE,MD21224
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0	cate be executed physician and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	C. Due to (or as	a consequ	uence of):							
68760			IF FEMALE:	d									
. Box 6	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours affer death. within 24 hours affer death. completed filled in by the funeral director, page 2 should be detached for use as to completed filled in by the funeral director, page 2.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 🗌 Feta	Ideath 3 🗌	Ectopic preg Other (specif				A	23d. Date of deli- Month	very Day Year
ds, P.O.		Completed by	Part II. Other significant conditions of	ontributing to death b	ut not resu	ulting in the un	derlying caus	se given in Pa	art I.				the cause of death?
Division of Vital Records,			25. Was case referred to medical							1 🗌 Yes	psy ormed?	prior to co death?	opsy findings available ompletion of cause of
Vita	tysiciar is certii directo	To Be	examiner?	Hospital:	ent 2 🗀 i	ER/Outpatient		6. Place of D Other:			idence (6 ☐ Other (Specif	(v)
n of	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of inju (Month, Day	у	28b. Time of injury	28c.	Injury at work?	2	28d. Describe			<i>11.</i>
Divisio	tal or Atten	l Certificate:	2 Accident Investigatio 3 Suicide 6 Could not to 4 Homicide determined					1 Yes 2		28f. Location (City or To		nd Number or Rura e)	al Route Number,
-	thin 24 hour thin 24 hour the Funera	Medical	(Check 2 L Medical Exam	sician: To the best of iner: On the basis of ex se Practioner: To the	camination	and/or investig	gation, in my c eath occurred	pinion, death at the time, d	occurred at ate and place	the time, date	and place ne cause(e, and due to the ca (s) and manner as s	ause(s) and manner stated trated.
	7. ¥ 7 . 8		Michael Landen	MEDIC	AL DO	CTOR		ES - C			29d. Da 0 C T O l	ate signed (Month, BER 26	Day, Year) 2009
			30. Name and address of person who MICHAEL SAVOER MID				,	BALTI	MARE	140	71	224	
	Stat	-	31. Date filed (Month, Day, Year)	32. Registra		•		OHLII	INE	Mp	<i>&1</i>	<i>□</i> = 1	

DHMH 17 Rev 7/2009

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Amend 10e per FH 8897 11/4/09 TT
State of Maryland / Department of Health and Mental Hygiene 35397 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Yea Hicks 1640 AM Zeog 2 /Medical 02 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death FUTURECARE-CANTON BALTIMORE If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Date of Birth (Month, Day, Year) 2 - 12 -1915 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2**X** F 213-16-6470 93 VA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Genter 308 Pine Street Funeral 21222 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Şq 1 □Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Specify. BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 DOMESTIC HOUSEWORK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ HENRY FLOWERS ANNIE FLOOD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FLORENCE PRIDE/DAUGHTER 1214 SEMINOLE AVE. BALTIMORE, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **STANISLAUS** 11/9/2009 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. Times a. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 15el rouncolar Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? VARCOlar deneuto 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 100 Ayor 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 25. Was case referred to medical examiner? 1 □ Yes 2 🗆 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier

or Attending Physician; The law requires that the death certificate be executed as the burial-tran and Division of Vital Records, P.O. Box 68760. physician attending use the signed by peen has After this certificate director,

Funeral

Director

show

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Pages 1 and 2 should be filed nent of Health and Mental Hygint; If Item 27 is marked other

permit. Pages 1
Department of F
Important: If Ite
any injury or ot
once.

Physician

Examiner

/Medical

other traumatic event, the Madical

72 hours after

Baltimore, Maryland 21215-0036

ρ be detached ģ Completed Be Certification: To funeral within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D1966 Eccool. 11-03-2009 10 ases 30. Name and address of pe on who completed cause of death (Item 23a) (Type, Print) Holisay \$508 Glea Boring Vary land Howard H 7310 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar Darks DHMH 17 Rev 1/2001

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			_ For	State of Ma	aryland / Depa	artment of H	lealth and N			egibie.	
			1 - State Registrar		Cei	rtificate of I	Death		Reg. No.	2009	35398
	Physici /Medic		1. Decedent's Name (First, Middle, Li William J. Harv	•				2. Date of De Month Novembe	er 1,	2009 ^{Year}	3. Time of Death 8:20A M
	Examir		4a. Facility Name (If not institution, gi 426 Amelanchier	,			Location of Death		4c. 0	County of Death	
VA.	F				e (In yrs. last birthday)	Be1A	11 If Under 24 Hrs.	9 Data of Pier	Ha.	Harfo	
	Funeral Director			-TXT M 2□ E	88 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da April	18,19	21 9. Birting Coun Ma:	lace (State or Foreign try)land
	land ow		10a. State 10b. County		10c. City, Town or Lo	cation				10	0d. Inside City Limits
	the Mary 28a-f sh	Director	Md. Balto).	N	ottingham	1		10 011	(1111)	1 □ Yes 2 No
	with Sa or	ä				10f. Zip Code 212	236		10g. Citiz	en of What Coun	try?
	hrs 2%	Funeral	9615 Trepid Rd.	12. Was Decedent 8	Ever in U.S. 13. V			ecify Yes or No	- 1	4. Race - Americ	an Indian
Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or Items 23a or 28a-f show event, the Medical Exacting must be mutified at		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1X□Yes 2□N	I	fYes, specify Cuba I⊡Yes 2 X ∏No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)		Black, White, e Specify: Whi	etc.
2-0	72 ho	eted	15. Decedent's E (Specify only highest gr		16a. Deced	dent's Usual Occup	ation during most of work		16b. Kin	d of Business/Inc	lustry
2	ithin ne.	Completed by	Elementary/Secondary (0-12)	College (1-4or 5	+) life. L	DO NOT use retirea	()			imore C	•
2	iled w Hygie Iher t	ပ္ပ	12 17. Father's Name (First, Middle, Las	2	Eng	ineer	40. 44-46			ng Auth	ority
an	should be fand Mental smarked o	o Be	Franklin Harvey	,			18. Mother's Name	Sche11	waiden 3	ourname)	
ar	shoul ind M i marl	1º	19a. Informant's Name/Relationship		19b. Mailin	a Address (Street a	and Number or Run		er. Citv or	Town, State, Zin	Code)
	and 2 ealth a n 27 is		Paul R. Harvey	Nephe		Amelanch				1. 21015	,
Baltimore,	of ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	20b. Place of Dispos cemetery, crem Bayview			Date -2009		ation - City or To	
a	permit. Page Department of Important; If any Injury or once.		21. Signature of Funeral Service Lice	**		. Name and Addres	45		_	eral Hom	
n	8 2 E 8 8		Buin a le	elle		9705 E	Belair Rd				
	Physician /Medical Examiner		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a.	the death. Do not ente	- 1	g, such as cardiac	or respiratory a	rest,		Approximate Interval Between Onset and Death
H		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b. — Due to (or as a	a consequence of):						
	scuted nd transit	Examiner	Cause. (Disease or injury that initiated events resulting in death) Last	c							
Ď,	certificate be executed ading physician and ise as the burial-transit	EX	resulting in death) Last	Due to (or as a	a consequence of):						
09/99	physicate I	dical	•	d							
O. BOX 6	or Attending Physicians: The law requires that the death certificate be executed interdeath. Interdeath. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	1		23	3d. Date of delive Month	ry Day Year
, ,	s that ned b e deta	by Pr	Part II. Other significant conditions	contributing to death bu	t not resulting in the un	derlying cause give	en in Part I.	23e. Did to	bacco us	e contribute to th	e cause of death?
ecords,	equires en sig ould be			Colon Co	ancer			1 □ Y	es 2 🔀	No 3□ Prob	ably 4 🗆 Unknown
Lecco	The law reture has be age 2 sho	Completed							sy med?	prior to con death?	osy findings available npletion of cause of
ָ ק	lan: rtifica tor, p	Be	25. Was case referred to medical				26. Place of Death		2 No	1 □Yes	2 🗆 No
> : 5 i	nysic his ce I direc	2	examiner? 1 Yes 2 No	Hospital: 1 Inpatier	nt 2 ER/Outpatient	t 3 □ DOA Othe				Other (Specify	Menhewstar
	ending Path.		27. Manner of Death 1. Natural 5 □ Pending 2 □ Accident investigatio	28a. Date of Injur (Month, Day		28c. Injury Work M 1 □ Y	at	28d. Describe h			
	o the Hospiral of Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ry - At home, farm, stre (Specify)	et, factory, office		28f. Location (S City or Tow	Street and n, State)	Number or Rural	Route Number,
:	o the Hospital rithin 24 hours a o the Funeral I ompletely filled	Medical (29a, Certifier 1	nysician: To the best o miner: On the basis of and manner stat	f my knowledge, death examination and/or inv ted.	occurred at the timestigation, in my or	ne, date and place, pinion, death occurr	and due to the red at the time,	cause(s) a	and manner as st blace, and due to	ated. the cause(s)
	or the	Ž	29b. Signature and title of certifier.	-		29c. License	number		29d. Date	signed (Month, L	Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11–5–09 vt State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No 2009 35399 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Рм Patricia I. Horner October 30, 2009 5:18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Bowie

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

January | June 26, 1 7303 Westwind Court Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 □ XF 73 - 83Director 187-26-9733 Pennsylvania 1936 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 28a-f show 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Directo 1 X Yes 2 □ No Maryland Prince George's Bowie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 "natural", or items 23a Funeral 7303 Westwind Court 20715 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 💢 Married Baltimore, Maryland 21215-0036 δ 1 ☐ Yes 2 X No Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. item 27 is marked other than other traumatic event, It is Man Elementary/Secondary (0-12) College (1-4or 5+) Executive Director Biomedical Engineer None Profit 12 Association 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Charles Louis Fox Dorothy Irene Penn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Horner/ Husband 7303 Westwind Court Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place, Arlington National Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 11/16/2009 Arlington, Virginia 21. Signature of Funeral Septi 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failers. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Chronic Obstructive Pulmoner 15 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 9☐ Unknown 5 ☐ Otner (specify) ☐Yes 2 2No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 XYes 2 No 3 Probably 4 Unknown peen 24a. Was an autopsy performed? 1 □ Yes 2 ○ No certificate has tirector, page 2 s 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No After this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) tembera 11-3-2009 00012015

State Registrar

DHMH 17 Rev 1/2001

6492 Landover Road Suite D Cheverly, MD 20785

30. Name and address of person who competed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

M.D.

Louis Steinburg,

31. Date filed (Month, Day, Year) NOV 0 4 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35400 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death Year 3:25 AM M 2009 Margaret Frances Herbert 10 31 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2 💢 F Months Days Hours Min. 08/26/1914 Maryland 214-01-3440 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 706 Hayden Court 21014 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes Z∭No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 C & P Telephone Co. Investigator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Wilhelm Carrie Gleissner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 706 Hayden Court - Bel Air, Maryland Richard A. Finck (grnadson) 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 11/03/2009 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 6. 11750 Belair Road - Kingsville, Maryland 21087 00 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS SYNDROME Due to (or as a consequence of): INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last URINARY TRACT Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectonic pregnancy in the past 12 months? Month Year Day ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 📉No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown ACUTE RENAL FAILURE, ALLITE MYOCARDIAL 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No INFARCTION, CORONARY ARTERY DISEASE 24a. Was an autopsy performed? Yes 22No HYPERLIPIDEMIA 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

bertimargaret m800487828

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria To the Hospital or Attend within 24 hours after death To the Funeral Director:

State

Physician

/Medical

Examiner

Director

Funeral

Completed

Be

MD

Funeral

Director

28a-f

9

or items 23a

and Mental Hygiene.

permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau

Physician

/Medical

Examiner

Examiner

Physician/Medical

\$

Completed

Be

Certification:

Medical

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

altimore, Maryland 21215-0036

10/31/2009

traumatic event, the Medical Examiner must be positived at

Registrar

DHMH 17 Rev 1/2001

DHANJANI

6 Could not be

Millerten

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

245 344

28f. Location (Street and Number or Rural Route Number, City or Town, State)

622 S.UNION AUE HAYRE DEGRACE, MD 21078

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH C897 11/04/09 JH/ #20b.c. perFH C897 11/19/09 WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3:47 AM John William Heil 26 10 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE 5. Social Security Number 16. Sex 8. Date of Birth (Month, Day,)

Jan • 19, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Hours 72 Yrs Jan. 1937 Director Maryland 213-34-0051 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Experience to sufficed an once. XXYes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? United States 10f. Zip Code Funeral 4537 Harford Road of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes XX No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) $\stackrel{\text{Elementary/Secondary (0-12)}}{12th}$ College (1-4or 5+) Self Employed Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental John William Heil ည Helen (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Wiatrowski (Niece) 21 Brookebury Drive, Apt. Cl, Reisterstown, MD 21136 20a. Method of Disposition Unk • 20b. Place of Disposition (Name of Tink cemetery, crematory or other place) Date Unic. 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Oner (Specify) Nov. 13,2009 Catonsville Metro Crematory 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. Signature of Funda Service Licen 11605 Reisterstown Road, Owings Mills, MD 21117 a. Pdv1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Imm diate Cause (Final disease or condition resulting in death) **Physician** Intra cranial hacmorrhage /Medical Examiner extension Sequentially list conditions, if any leading to instruct lat-cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar to (or as a consequence of): P.O. Box 68760, Spiration Physician/Medical phlumonia 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 \(\overline{V} \) No within 24 hours after death.

To the Funeral Director; After this certificate completely filled in by the funeral director, page 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ipital: 11 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of Injury
(Month, Day, Year)
28b. Time of
Injury
28c Certification; To 27. Manner of Death
1 Natural
2 Accident 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) To the Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10/26/09 W. D address of person who completed cause of death (Item 23a) (Type, Print) Deep Sharma Baltimose Hospital

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

4 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar			State of I	Mary	land /		rtmen ificate			and M		Reg	ne . No.	2009)	354(12
	Dhusisian		. Decedent's Name				Uon	~						2. Date of Month		Day	Year		. Time of Deat	h M
	Physiciar Medica	al _	Myun a. Facility Name (if		IM	et and numbe	Hon	8		4b. City,	Town, or	Location		Noven	nber		2009 County of Dea		<u>:45 p.</u>	
	Examine	er 4	Randolph					r			aton				Montgomery					
	Funeral Director	5	5. Social Security No.	umber	6. Sex	M 2 X F 7.	Age (In	yrs. last bi	irthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Apri	f Birth Day 9	ear) 1	920 K	rthplace puntry) OTE	e (State or For a	eign
		. h	Jsual Residence of				10	c. City, To	wn or Loc	ation								10d.	Inside City Lir	mits
	ryland	Director	10a. State MD	Montg	omer	v		Burto											1 🗆 Yes 2🗶	XNo
	or 288	흠	10e. Street and Nur							10f. Zip	Code					•	zen of What C		?	
	with the same same same same same same same sam	Funeral	14618 A1	manac	Dr.					208				" M			ed Sta		Indian	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	11. Marital Status 1 Never Marr 3 Widowed		rried	Armed Force 1 Yes 2 If Yes, Give Year or Date	es? Y No	in U.S.		Vas Deced Yes, spec			rigin? (Spe an, Puerto y:	cify Yes or Rican, etc.))		14. Race - Am Black, Wh Specify: As	ite, etc.		
8	hours natura lical E	lete		15. Decede	ent's Educ	ation		16a. Decedent's Usual Occupation (Give kind of work done during most			st of worki	ing	- 11	l6b. Kii	nd of Busines	s Indust	try			
Maryland 21215-0036	iin 72 ie. han "r e Med	Completed	Elementary/Sec		est grade	College (1-4	or 5+)		life. D	ö <i>not use</i> naker	e retired)					Owr	Own Home		- 1	
121	d with tygien ther t	Be C	17. Father's Name		Last)				nome	naker		18. Mot	ther's Name	e (First, Mi	ddle, M					
and	be file ental l ked o ic eve	일	(not kno		,								Knov							
ary	hould and M is mar		19a. informant's N	ame/Relations	ship <i>(Type</i>	, Print)											Town, State,			
Σ	nd 2 s ealth: m 27		Kyu Hong			(son)		20h Place	e of Disno	sition (Na	me of	Dr.	Burt	tonsv Date	1116	20c. Lo	Marylar ocation - City	10 Z or Town	, State	
Jore	ge 1 a nt of H :: If ite		20a. Method of Dis	☐ Cremation		emoval from S		ceme	1 avan	natory or	other place		Nov. 2009				kville			
Baltimore,	ermit. Pa epartme nportani ny injury		4 ☐ Donation 21. Signature of Fi	une al Service				00982	2	2. Name a	nd Addre	ss of Fac	Rapı Silve	p Fun er Sp	eral	L &	Crema Maryla	tion nd 2	Servi 20910	.ce
ш	<u>20</u> = # 0		23a. Part 1. Enter	the disease	or compli	ions that ca	used th					_						A	pproximate	en.
	Photological Confession (shock, or he Immediate Cause	art failure. List (Final	only one	cause on eac	II III IO.	mer's											nset and Dea	
	Physician/ Medical		disease or condit resulting in death		C a			onsequen												
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14	ed nsit	Examiner	if any, leading to cause. Enter Und Cause (Disease of	erlying 1 or iinjury	5 .											_				
Ba	ate be executed hysician and the burial-transit	Exa	that initiated ever resulting in death			Due to (c	or as a c	consequen	ice of):									1		
09	rte be hysicia	dical													_	_				
Division of Vital Records, P.O. Box 687	Attending Physician: The law requires that the death certificate be executed sr death. ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)											23d. Date of Month		y Day Yea	ar			
0	requires that the de been signed by the should be detached	/ Phy	9 Unknow		itions cor	ntributing to de	eath but	t not result	ing in the	underlyin	g cause g	jiven in P	art I.	23e					cause of dea	
8	uires the signer of signer	ed b																	ably 4 🔀 Un	
ecord	sician: The law requ s certificate has bee lirector, page 2 shou	Completed by													a. Was a autop perfor Yes	sy med?	prior deat	to com	sy findings ava pletion of cau	ise of
<u></u>	ian: T ertifica ctor, p	Bec	25. Was case reference	erred to medic	_	lospital:					101		Death (Che				<u> </u>			
Š	hysic this ce	은	1 🗆 Yes	2 XNo		1 L	of injury		R/Outpat 8b. Time		DOA 28c. Inji	ury at	Nursing I	$\overline{}$			6 Other (S	іресіту)		
Č	ding I th. After	cate	1 X Natural 2 Acciden	5 Per	nding estigation	(Mon	th, Day,	Year)	injury	М	1 [rk? Yes 2	2 🗆 No _							
visio	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Certificate:	3 Suicide 4 Homicio	6 Co	uld not be ermined	Zoe. Flace	of Injur	y - At hom (Specify)	ne, farm, s	street, fact	ory, office	Э		28f. Loc City	ation (S or Tow	treet a n, Stat	nd Number o e)	r Rural F	Route Number	r,
Ē	Spital hours a neral C	Medical (1x Certify	ing Phys	ician: To the b	est of n	ny knowle	dge, deat	h occured	at the tin	ne, date a	and place, th occurred	and due to	the cau	use(s) a	and manner a ce, and due to	s stated the caus	d. se(s) and man	ner stated
	the Ho nin 24 the Fu	Med	(Check only one)	3 L Certify	ing Nurs	ner: On the base e Practioner:	To the b	pest of my	knowledg	e, death oc	ccurred at 29c. Licer	tito tirrio;		lace, and d			e(s) and manne ate signed (N			
	Vith To 1		29b. Signature a	nd title of cert	inter ()		12 2	n (/	/			261					rember			
	\		30. Name and ac	ddress of pers	son who c	ompleted cau	se of de	eath (Item 2	23a) (Type Cir	Print)	Silv	er S	 Spring	g, Ma	ryla	and	20906			
	\ 9;	ate	31. Date filed (M	onth, Day, Yea	ar)			r's Signatu		A 40										
	Regis			0 4 20		Mound		A. A	BARR											

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RWILLES

alle

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 1027/2009 21237 9000 FRANKLIN Square DR Balto in d

Year

2009

0800 AM

9. Birthplace (State or Foreign

Black

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

New York

State Registrar

Medical

4 T Homicide

29b. Signature and title of certifier

STUART

31. Date filed (Month, Day, Year)

FranTC

NOV - 4 2009

29a. Certifier

DHMH 17 Rev 1/2001

within 24 hours a

To the Funeral I

completely filled To the Hospitai

ORIGINAL

29c. License number

D36663

			For State Registrar	State of Mar	yland /	Departmen Certificat				giene _{Reg. No.} 2	11114	35404
	Physicia /Medic		1. Decedent's Name (First, Middle, La Earline C. 3	Horton					2. Date of De Month	ath Day 28	Year 2009	3. Time of Death /:28 PM
4	Examin	er	4a. Facility Name (If not institution, given Johns Hopkins Basses) 5. Social Security Number 6.5	yview Med	Lical Ce (In yrs. last bi	inter Br	1/Ear	Location of Death MORE If Under 24 Hrs.	8. Date of Bir		unty of Death	place (State or Foreign
	Director		Usual Residence of Decedent				Days	Hours Min.	8. Date of Bir (Month, Da 1/14/3	80 		AL
	e Marylan ka-f show	ctor	AL 10b. County Coll	pert	10c. City, Tow	rn or Location Tuscumb	ia					10d. Inside City Limits 1XXes 2 □ No
	th with the 23a or 28 ast be no	al Dire	10e. Street and Number 605 East 10th	Street		10f. Zip		35674			n of What Cou SA	ntry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evanimer must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3CXVidowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 □Yes 2 ▼No If Yes, Give Year or Dates:		13. Was Deced If Yes, spec 1 ☐ Yes		spanic Origin? (Spen, Mexican, Puerto I	cify Yes or No Rican, etc.)		Race - Ameri Black, White, pecify: b	
21215-0036	within 72 ho iene. than "natul he Medical	ompletec	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)		life. DO NOT us	rk done d	uring most of working	ng		of Business/Ir	
Maryland 2	uld be filed Aental Hyg rked other tic event, I	To Be C	17. Father's Name (First, Middle, Last Clark Cole					18. Mother's Name	(First, Middle die Bra		rname)	
	ind 2 shousalth and N 27 Is mail		19a. Informant's Name/Relationship Frances Brown /		19			nd Number or Rura Meadow Co				ip Code) IN 38138
altimore,	Pages 1 annent of He ant: If Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		cemete	of Disposition (Nat ery, crematory or o dd Cemete	ther place		09		tion - City or T Tuscum l	own, State
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service Lice	nseVictor P.	Doda,	Charte	≃ട∟.	s of Facility Stevens Fort Ave	Funera Balti	l Hom	e, Inc.	30
8760,	Physician // Medical Examiner buyasician and the prijel-transit	dical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line	moniconsequence	a of): y Faill of):						Interval Between Onset and Peath Weeks hours
P.O. Box 6	ath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal deat			1		23	d. Date of deli Month	very Day Year
	uires that I signed by d be detai	d by Ph	Part II. Other significant conditions	contributing to death but	not resulting	in the underlying	cause give	en in Part I.				the cause of death?
II Recor	: The law req cate has beer page 2 shou	Completed by							24a. Was auto perfe 1 □Yes		prior to c death?	topsy findings available completion of cause of 2 □ No
f Vita	hysiclan his certifi I director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	t 2 🗆 ER/0	Outpatient 3 □ D		4 LI Nursing Ho			Other (Spec	cify)
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Accident 4 determined	e 280 Place of Injur	Year)	М		Yes 2 □No	28d. Describe 28f. Location City or To			rral Route Number,
[,	e Hospita 124 hours e Funeral letely filled	Medical C	29a. Certifier (Check only one) Certifying P 2 Medical Exa	hyslcian: To the best of miner: On the basis of e and manner state	examination a	ge, death occurred and/or investigatio	d at the tir	me, date and place, pinion, death occur	and due to the	e cause(s) a , date and p	nd manner as lace, and due	s stated. to the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier	Ill			RES	-000		0.4	signed (Month	0 2009
_			30. Name and address of person who WACHIPAPON	TORDAN Pi	luek	MD. 4	940	Eastern Ava	une B	altimor	e,MD.	21224
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 4 2009	32. Registrar	rs Signature	and						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	For State Registrar	State of Mary	land / Depa <i>Cei</i>	artment of F rtificate of I	lealth and I D <i>eath</i>		iene 200 eg. No.	9 35405			
Physicia /Medica		1. Decedent's Name (First, Middle, Shirley	R. Hatf	ield			2. Date of Death Month OCTOBER	Day Year	S CH V M			
Examine Funeral Director	r		rial Hospital	n yrs. last birthday) 74 yrs.	4b. City, Town, or If Under 1 Year Months Days	Baltimon If Under 24 Hrs. Hours Min.		4c. County of De Year) 9. B	ath N/A irthplace (State or Foreign Sountry) MD			
4.7	tor	Usual Residence of Decedent 10a. State 10b. County MD	N/A 100	c. City, Town or Lo	cation Baltimo	re	37 137 3		10d. Inside City Limits 1 □ Yes 2 □ No			
th with the 23a or 28a	I Director	10e. Street and Number 607 East Cleme	nt Street		10f. Zip Code 212	30	11	0g. Citizen of What C US	•			
items items	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Midowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes ※XX No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ☑ No	ispanic Origin? (S an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, ite, etc. white			
W	Completed	15. Decedent: (Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	I (Give	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Hom				
ire, Maryland 212 st and 2 should be filed within of Health and Mental Hygiene. item 27 is marked other than other traumatic event, INSM	To Be C	17. Father's Name <i>(First, Middle, L</i> John Fah	ast) r Hunt				ne (First, Middle, N illian Ha	Maiden Surname) rnesberge	r			
Mary od 2 shou lith and M 27 is mar		19a. Informant's Name/Relationsh Janice L. Tross		1	•			; City or Town, State	, Zip Code)			
Baltimore, Mispermit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tranonce.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - Cit										
Balti permit. Depart Imports any Inji		21. Signature of Funeral Service 1	omplications that caused the						nc. ryland 21230 Approximate Interval Between			
Physician /Medical Examiner tianutitiansit	Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							Onset and Death Tokeys Zugers			
C. Box the death cert by the attending	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 VANo 9 □ Unknown	d	Fetal death 3	□ Ectopic pregnand □ Other (specify) _	cy		23d. Date of o	delivery Day Year			
cords, F	2	Part II. Other significant conditio	ns contributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.			to the cause of death? Probably 4 Unknown			
Vital Recorr Iclan: The law requ certificate has been ector, page 2 should	Completed							y prior t ned? death 2 Stylo 1 □ Y	autopsy findings available o completion of cause of ? es 2 \(\square\) No			
r Attending Physer death.	Certification: To Be C	å	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day, Ye	- At home, farm, str	of 28c. Inju Wor M 1 □	er: 4 🗆 Nursing H	28d. Describe ho	ence 6 Other (Some injury occurred treet and Number or	pecify) Rural Route Number,		
ca_ 5 ca	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical	g Physician: To the best of m examiner: On the basis of ex- and manner stated	amination and/or in	th occurred at the to	me, date and plac opinion, death occ	e, and due to the durred at the time, d	cause(s) and manner late and place, and c	as stated. lue to the cause(s)			
To the within To the comple	Me	29b. Signature and title of certifier	MD		29c. Licens			OCTOBER	27 2009			
				h (Item 23a) (Type,	Delet							
Stat Registra		31. Date filed (Month, Pay, Year)	UUY 22. Registrar's	Signature And	Red	<u> </u>	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 07 20 AM HACK Novemeber SYLVAN 2609 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore HOSbital ol Baltimore Lit If Under 1 Year If Under 24 Hrs 8. Date of Birth Month, Day, Year 01-17-19 18 Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) **Funeral** 91 Director 218-03-0938 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 □ No Director BALTIMORE MD N/A 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21209 USA 6202 IVYMOUNT ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: þ WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STATISTICIAN SOCIAL SECURITY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HACK ALEXANDER HANNAH BELMAN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6202 IVYMOUNT ROAD, BALTIMORE, MD 21209 BIRDIE HACK/WIFE permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON CHIZUK AMUNO 11-03-2009 BALTIMORE, MD Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROTHERS. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part. Enter the disease or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final A cute My O Cardial

Due to (or as a consequence of): 188 **Physician** disease or condition resulting in death) /Medical Examiner Middle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner bertens Due to (or as a consequence of): burial-Division of Vital Records, P.O. Box 68760, Physician/Medical the attending pl IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an autopsy performed Yes 2 No 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **☑** No 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 🗍 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral L 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 1 dushi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Sinai Hospital 32. Registrar's Sign 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year JOHNSON MARY 2009 : 05 PM /Medical Ctropped 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLSTOWN SEASONS HOSPICE BALTIMORE Date of Birth (Month, Day, MAY 2, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (Olan. Country) ANTIGUA ce (State or Foreign **Funeral** 1 □ M 2 😿 F Director 78 115-22-3784 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f showere, the Madical Examinar must be notified at 1xxXYes 2 □ No Director BALTIMORE DUNDALK MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 1 103 CENTER PLACE APT. 329 21222 USA by Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. and 2 should be filed within 72 hours after of tealth and Mental Hygiene. Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2**X** No Specify: Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PILGRIM ST. HOSPITAL NURSE 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Menta ျှ ALFRED JOHNSON ELAINE GARDNER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENISE SAUNDERS/GRANDDAUGHTER 8 ETHEL LANE MEDFORD, NY 11763 Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If its any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 11-6-2009 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic Cardiovascular Disease Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Duc to for as a consequence of death certificate be executed burial-transi Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) the ☐Yes 2☐No 9 Unknown 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No has 24a Wasan certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Hospital: 1 Yes 2 No After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Man r of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the and manner stated. 29b. Signature and title of certifien 29c. License number 29d. Date signed (Month, Day, Year) MSKAJADAKRM.D P0057465 25 Main St., Suite 200, Reisterstown, MD. 21136 30. Name and address of person who completed cause of death (item 23a) (Type, Print) apakse, Rai egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \(\Omega\) \(\Omega\)

Physici /Medi Examir

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is it offer Expring I. Instituted and once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1 - State of Maryland State of Maryland	d / Depa <i>Ce</i>	artment of H <i>rtificate of L</i>	ealth and I <i>eath</i>		ene 2009	35408			
an cal	1. Decedent's Name (First, Middle, Last) CLARA ELESEBETH	,	SOHNS	on	2. Date of Death Month	Day Year R 1, 2009	3. Time of Death			
er	4a. Facility Name (If not institution, give street and number) 7837 FREETOWN ROPE	D	4b. City, Town, or GLEN B			4c. County of Death	1			
	5. Social Sécurity Number 6. Sex 1 M 2 F 7. Age (In yrs. la 1 Usual Residence of Decedent	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		nplace (State or Foreign untry) RYLAND			
tor	10a. State 10b. County 10c. City,	Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
1 Director	10e. Street and Number 7837 FREETOWN ROAD	D	10f. Zip Code	060		g. Citizen of What Co	untry?			
Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 1 Never Married 2 Married 1 Yes 2 Mar No		Was Decedent of His If Yes, specify Cubar	panic Origin? (Sp., Mexican, Puerto	pecify Yes or No-	14. Race - Amer Black, White				
eted by	3 ▼ Widowed 4 □ Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	16a. Dece	1 ☐ Yes 2 Mo Ident's Usual Occupa Is kind of work done di	Specify: tion tring most of work	10 kina	Specify: Book Business/I	LACK ndustry			
Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired) アバンTRESS	PRESS	SER V		CLEANER			
To Be	17. Father's Name (First, Middle, Last) OTTO COA			ELEXZ.		H	ARRIS			
	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEMA JACKSON (DAUGHTER) 7837 FREETOWN RD-, GLEN BURNIE, MD & JOGO 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State									
	1 N Buriat 2 Cremation 3 Removal from State	metery, crei こんらい	matory or other place	m. 11/0	12009 CF	ROWNSYILL	E, MARYLAN			
	23a. Part 1. Enter the disease, or complications that caused the death.	20 2	MON. FU	BROW LTON AV	E.13471		D 2/2/7 Approximate			
al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or a jury that initiated events resulting in death) Last Due to (or as a consequence of a jury that initiated events resulting in death) Last Due to (or as a consequence or a jury that initiated events resulting in death) Last		Onset and Death							
Completed by Physician/Medical	d	death 3	Ectopic pregnancy			23d. Date of deli Month	very Day Year			
ted by PI	Part II. Other significant conditions contributing to death but not result	ting in the u	nderlying cause give	in Part I.	23e. Did toba	acco use contribute to	the cause of death?			
Comple		prior to o death?	topsy findings availabl completion of cause of 2 No							
Certification: To Be	1 Datural 5 Pending (Month, Day, Year) 2 Accident investigation 3 Suicide 6 Could not be	28b. Time o Injury	ont 3 DOA Other	4 ☐ Nursing Heat	28d. Describe how	ce 6 Other (Spec				
Medical Certif	4 Homicide determined 228. Place I minuty - Artiform 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	use(s) and manner as e and place, and due	stated.							
Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11309									
	30. Name and address of person who completed cause of death (Item 2) The person of person who completed cause of death (Item 2) The person of person who completed cause of death (Item 2) The person of person who completed cause of death (Item 2) The person of person who completed cause of death (Item 2) The person of person who completed cause of death (Item 2) The person of person who completed cause of death (Item 2) The person of person who completed cause of death (Item 2) The person of person who completed cause of death (Item 2) The person of person who completed cause of death (Item 2) The person of person who completed cause of death (Item 2) The person of person of person who completed cause of death (Item 2) The person of pe	6	Print) A Ma	gothy	Beach	Rd Pasa	Idena, M			
e ir	NOV 04 2009	1. 19	acted !				011			

Registrar

			1 - For State Registrar	State of Maryl		artment of He rtificate of D		, ,	ene 9. No. 2009	35409	
	Physic		1. Decedent's Name (First, Middle, La Rolf	Bradford	Joh	ıannesen		2. Date of Death Month ovember		3. Time of Death 2:25 p. M	
- 14	/Medi Examir		4a. Facility Name (If not institution, gi Holy Cross Hospit	· ·		4b. City, Town, or L Silver S	ocation of Death		4c. County of Death	1	
	Funeral Director		5. Social Security Number 6. 376-20-5307		yrs. last birthday) Yrs.			B. Date of Birth (Month Day, OV • 3,	9. Birth	place (State or Foreign	
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgor		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☒ No	
	th with the 23a or 28a	ral Director	10e. Street and Number 3114 Gracefield I	Rd. Apt. 215		10f. Zip Code 20904	_		10g. Citizen of What Country? United States		
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, if a Medical Exyminer must be indiffed a once.	d by Funeral	11. Marital Status 1 ☐ Never Married 2K Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☑Yes 2 ☐ No 1 If Yes, Give Year or Dates:	94 7- 948	Nas Decedent of Hisl f Yes, specify Cuban, I □Yes 2ሺNo	panic Origin? (Spec , Mexican, Puerto Ri <i>Specify:</i>	ify Yes or No- ican, etc.)	14. Race - Amer Black, White, Specify: Wh:	etc.	
Maryland 21215-0036		Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5+) 5+	16a. Deced (Give life. L Chemi	dent's Usual Occupat kind of work done du DO NOT use retired) St	ion ring most of working	'	6b. Kind of Business/II Federal Gov		
land 2		To Be C	17. Father's Name (First, Middle, Last Rolf Johannesen			1	8. Mother's Name (aiden Surname)		
, Mary	and 2 shore ealth and 1 in 27 is mare trauma		19a. Informant's Name/Relationship	en (son)	13392	Sousa Lar	ne, Sarat		City or Town, State, Zi Lifornia 9!		
Baltimore,	Pages 1 a tment of He tant; If item jury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Content of the Conten	Themoval noin state At	hesapeak	sition (Name of natory or other place) .e Cremato:	ry 2009	3, I		, Maryland	
Bai	permir Depar Impor any in		21. Signature of furth al Service Lice	M00	982 93	3 Gist Ave	e. Silver	Spring,	, Maryland		
	Physician /Medical		23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Septic Sho	ck	er the mode of dying,	such as cardiac or	respiratory arres	st,	Death mery	
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	Due to (or as a cons b. Enterocoli Due to (or as a cons	tis						
68760, «	eath certificate be executed attending physician and for use as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	sequence of):						
P.O. Box 6	The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of prediction 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of Unknown		23d. Date of deliv	•				
rds, F	w requires that been signed I should be deta	ed by P	Part II. Other significant conditions of Atrial Fibrilla		resulting in the un	derlying cause given	in Part I.				
Vital Records,		Completed	Myelodysplasia					24a. Was an autopsy performe	prior to co ed? death?	ompletion of cause of	
	ysiciar is certif directo	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🖾 No	Hospital: 1⊠ Inpatient 2	T 57/0:	Other	26. Place of Death (
Division of	£ 5-	ation: To	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year,	28b. Time of	28c. Injury a Work?	4 LI Nursing Home	d. Describe how	ce 6 ☐ Other (Special injury occurred	ify)	
Divis	tal or Atteners after death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spe	t home, farm, stre	et, factory, office	28	f. Location (Stre City or Town,	et and Number or Rui State)	al Route Number,	
)	To the Hospital or within 24 hours after To the Funeral Direction completely filled in the complete of the com	Medical	29a. Certifier 1 △ Certifying Ph (Check only one) 1 △ Certifying Ph 2 ☐ Medical Exar	nysiclan: To the best of my kinner: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the time restigation, in my opir	, date and place, an nion, death occurred	d due to the cau	use(s) and manner as e and place, and due	stated. to the cause(s)	
	North Con	2	29b. Signature and title of certifier	Kemeli					Date signed (Month,		
	5+1		30. Name and address of person who Andrew G. Kundrat	, M.D. 3110	Gracefi	eld Rd. Si	ilver Spr	ing, Mar	cyland 2090	04	
H	Stat Registra		31. Date filed (Month, Day, Year) NOV 0 4 2009	32. Registrar's Sig	gnature	,					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2∞ Physician/ 2:30AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death timore mming Funeral 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign 8. Date of Birth 1 M 2 X Months Hours Director Carolina Usual Residence of Decedent or 28a-f shov 10a. State 10b. County Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral umminas 2. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' life. DO NOT use retired) 8 conday (0-12) College (1-4 or 5+) Q Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Libenses 110155 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ 4theroscherottc disease or condition resulting in death) Cerediovasculae Pai Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or iinjury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown g Unknown signed I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 page or Attending Physician: The 1 L Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 🗌 Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 💢 Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural Division 5 Pending within 24 hours after death.

To the Funeral Director: A 2 🗌 No М 1 Yes Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined the Hospital Medical 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 10 29c. License number 32158 completed cause of death (Item 23a) (Type, Print) Catonguille MAS 2/228 ollin 576 N. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

300

MM sn)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 6:10 P M HARRY KIMMEL 2009 30 October 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Baltimore Towson If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/15/1917 Birthplace (State or Foreign Country)
 MD **Funeral** sex 1**X**□M 2□F Months Days Hours Min 217-01-3472 92 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Profical Examiner must be notified at 1 □Yes 2 No Director MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 WALTHER BLVD., #1419 21239 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 X Yes 2 □ No If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: þ WHITE 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WINDOW TRIMMER RETAIL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H LOUIS KIMMEL IDA ပ MOSKOVIT7 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is n DOROTHY KIMMEL / WIFE 8810 WALTHER BLVD., #1419, PARKVILLE, MD 21239 Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If it any Injury or c HAR SINAI 11/02/2009 OWINGS MILLS, MD 4 □ Donation 5 □ Other (Specify) 21. Sig ur of Funeral Service Licen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Myocurdi resulting in death) /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as the attending IF FEMALE: use ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Por 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, òq æ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the transfer death.

Within 24 hours after death.

To the Funeral Director: After this certificate I committee in light the funeral director, page performed 214No 2 🗆 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes မ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

4

State Registrar 30. Name and address of person who

31. Date filed (Month, Day,

Gosne

32. Registrar's

Suite 550 N. Pavillion

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **JOSEPH** F. KILPATRICK Ш October 2054 12:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore washing ton Mudical center Glen burning Anne forwarde Social Security Number 213–80–6733 If Under 1 If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 KM 2 D F June 1959 Country) land **Director** Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Arundel Pasadena Maryland Anne 1 🗌 Yes 2 🄀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4002 Mountain Road 21122 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc Completed by 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 No Specify. Specify 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Atlantic Marina Resort Master Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph F. Kilpatrick Marlene Eaton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa G. O'Connell 4002 Mountain Road, Pasadena, Maryland 21122 (Sister) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 S Cremation 3 Removal from State Atlantic Crematory Nov. 03, 2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal rvice Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadeña, Maryland 21122 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician/ disease or condition Medical resulting in death) to lot as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 WUnknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy death? 1 ☐ Yes 2**X0**No certificate Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Nnpatient 2 ER/Outpatient 3 DOA within 24 hours ar er death.

To the Funeral Director: After this completed filled in by the funeral direction. 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 32

Registrar

State

31. Date filed (Month, Day, Year)

30

2. Registrar's Signature

and address of persol who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month TOB Medical 4a. Facility Name (if not institution, give street and number) City Town, or Location of Death Examiner 4c. County of Death 19 timore JOSEPH If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Months (Month, Day, 220-64-338 54 **Director** JANUARY 15 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits Director 1 ☐ Yes 2 🗷 No ROSEDALE MARYLAND BALTIMORE 10e. Street and Number ō 10g. Citizen of What Country? Funeral and Mental Hygiene. is marked other than "natural", or items 23a U.S.A. KING CHARLES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?, 1 ☐ Yes 2 🗷 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🖬 No Specify: If Yes Give 10/23/09 (5.7) Baltimore, Maryland 21215-003 Specify: BLACK Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH GRADE ST. AGNES HOSPITAL PHARMACY TECHNICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ GRANT LILLIAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau GREGORY (HUSBANUD) OLO KINGCHARIES CIRCLE, ROSEDALE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) MARYLAND NATIONAL CEM. 10/31/2009 LAUREL, MARYLAND 22. Name and Address of Facility
SOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE., BALTIMORE, MD 21217 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Breast cancer Pnysician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physici ivision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Dav Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. **Other significant condition**s contributing to death b*u*t not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Mesidence 6 Other (Specify, Hospital: 2 No 1 🗌 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D51788 10-23-09 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 620 Boulton Street Air MD 31. Date filed (Month, Day, Year) NOV 0 4 2009 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Physician STEPHEN OCTUBER ,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MANOR BALTIMORE CARE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□F Months Days Hours Min 219-76-7975 Yrs. AUGUST 11,1958 MARYLAND Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medican Evantinet must be notified at once. 28a-f show 1 ☐ Yes 2 No Funeral Director CALTIMORE TOWSON MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 509 E. U.S.A 50PPA 21286 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify: Specify: BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GRADE UNKNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (AND) MUBLEY ပ RUSSELL MATTIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21286 AIRWAY CIRCLE, BALTIMORE, MD RUBY ROBINSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State WERAL HOME + CREMATERY: 11/04/2009 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
JOSEPH H, BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licensee Illiamo 2140 N. FULTON AVE., BALTIMORE, MID 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 9 Hinknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 tonknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🖸 2 **11** No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) this c /2 No Other: 1 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Man r of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Natural 1 □Yes 2 🗆 No after death Director: / d in by the f 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🖺 Homicide n 24 hours aff e Funeral Di lletely filled ir 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

State

within 2 To the

DHMH 17 Rev 1/2001

Registrar

29d. Date signed (Month, Day, Year)

Woods loud. MD 2R34

and manner stated.

eted cause of death (Item 23a) (Type,

and title of certifier

30. Name and address of person who comp

29b. Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4a. Facility Name (if not institution, give street and number) Upper Chesapeake Medical Center 4b. City, Town, or Location of Death Harford 4c. County of Death Harford Funeral Director 5. Social Security Number 213.13.0990 1 M 2 F 23 Yrs. Isst birthday) Usual Residence of Decedent 10a. State 10b. County 11c. City, Town or Location 10d. In P. 21 A 4	e of Béalth 14 hrs
Medical Examiner Jason Andrew Lawrence 4a. Facility Name (if not institution, give street and number) Upper Chesapeake Medical Center Funeral Director Funeral Director Lawrence 4b. City, Town, or Location of Death Harford 4c. County of Death Harford 5. Social Security Number 213.13.0990 1 M 2 F 23 Yrs. 106. City, Town, or Location of Death Harford 4c. County of Death Harford 106. 26.1986 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. In 10d. In 110d. I	14 hrs
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10f. Zip Code 10g. Citizen of What Country?	765 2
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TOTS ETITEOUT DELVE 21015 U.S. A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	ian Black
Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. White, etc. White	, 2.05.1,
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done) 16b. Kind of Business/Industry	
Specify: Specify:	
School of the state of the stat	1
17. Father's Name (First, Middle, Last)	
To get to	ode)
The property of the property o	
Lisa Lawrence/Mother 1013 Ellicott Dr. Bel Air. MD 2101 20a. Method of Disposition (Name of cemetery. Date 20c. Location - City or Town, S	State
200. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Chesapeake Crem. 11.03.09 Beltsville, Chesapeake Crem. 22. Name and Address of Facility CAFA/Stephen D. Lohrm 8717 Green Pastures Dr. Balto.	
and she want 101995	MD roximate Interval
Medical failure. List only one cause on each line.	ween Onset and Death
xaminer Immediate Cause (Final disease a. Multiple Gunshot Wounds	Death
b.	
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The second of th	
The state of the s	
FOUND: FOUND: January Subject shot by police	
28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Rot or Town, State)	ute Number, City
determined (Specify) Single Family 1013 Elliott Drive, Bel Air, MD	
Set 15 5 5 5 7 6 15 15 15 15 15 15 15 15 15 15 15 15 15	se(s)
and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Date signed)	
O.C.M.E. November 1, 2009	
30. Name and address of person who completed cause of death (Item 23a)	
Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
24 Data Flord Maryll Day Veryl	
State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature Registrar NOV - 4 2009	

3:00

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

Birthplace (State or Foreign Country)

Baltimore, MD.

White

21093

21093

Day

Year

Approximate Interval Between nset and Death

State Registrar 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4RONS ODER. 28 /Medical 4c. County of Death or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NIC soital Birthplace (State or Foreign Country) 1 Year If Under Date of Birth (Month, Day, Year) 5. Social Security Number (In vrs. last birthday **Funeral** Months Days 1 M 2 □ F 220-74-7078 MARYLAND MARCH Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director BALTIMORE MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number J. S.A. 21217 532 STREE 7 Robert Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 M Married 1 ☐ Yes 2 🗷 No Specify Specify: BLACK ≥ permit. Pages 1 and 2 should be filed within 72 hours. Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Evenes. 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COMPANY LIFT CANNING DRIVER 10TH GRADE FORK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MYERS IRENE WILLIAM ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) APT. 3D, BALTO., MD 21215 EBERLE 6602 MYERS WIFE DEBORAH Baltimóre, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition FUNERAL HOME + CREMATOR 11/04/2009 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME SUYONI, FULTUNI AVE, BALTIMORE, MD SUSIT Miams 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one carries on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ₹ Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Box 68760, physician Physician/Medical the attending p yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death g ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No Physician: The certificate 1 ☐Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To this 28b. Time of 28d. Describe how injury occurred 27. Mannet of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 24 hours after death. E Funeral Director: After letely filled in by the funeral Hospital or Attending Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

Registrar

30. Name and ad

Date filed (Month, Day, Year) NOV 0 4 2009

racks

Place Suite 3H Bacto, md. 2120/

MM

300

ess of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mannel October 10:55 AM orraine 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hopkins Bayview Medical Center Baltimore Johns 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD Funeral 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth 1 □ M 2 🗓 F Min. 0 9-16-1948 61 Director 217-52-9403 Usual Residence of Decedent should be filed within 72 nours arranged.

I and Mental Hygiene.

I is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Harford MD Bel Air 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21015 USA 104 Canvas Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Completed by 1 Yes 2 💢 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours popartment of health and Mental Hygene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cosmetologist Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Peter M. Tatarewicz Dolores L. Cushing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa L. Ward 120 Cedar Ridge Lane Hendersonville, TN 37075 (Niece) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 10-31-2009 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licenses Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Preumonia ₽nysician/ disease or condition Medical resulting in death) Examiner Epidural Abscess Nical Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) Pregnant at time of death ed by the a g Unknown g Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown icate has been sig r, page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Serform death? After this certificate Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗆 No မ 1 Pinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 1 1 Natural injury 5 Pending 1 Yes 2 No death. 2 Accident
3 Suicide
4 Homicide neral Director: A Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number after determined City or Town, State within 24 hours a

To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

Registrar

(Check

only one)

29b. Signature and title of cortifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hernandez

M.D.

32. Registrar's Signature

4940

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

October 27, 2009

Eastern Avenue Ballimore, MD 21224

29c. License number RES-000

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Las, 2. Date of Death MCRAE worth were Physician ARAH /Medical County of Death Facility Name (If not institution, give street and number) **Examiner** Seasons Hospice at North west Boutinore Kandallstown If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗹 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at BaHimore 1 Des 2 No by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1SA 2121 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 2 00 1 Never Married 2 Married 0 Maryland 21215-0036 1 ☐ Yes 2 Z No Specify 3 ₩idowed 4 Divorced Black Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) bme maker Domest 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Watkins Benjamin eorgianna P 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any Injury or other tra 8319 B. Mindale C Windsor MilliMDZ1244 Donna washinatan Daughter ir. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11-07-2009 Hamlett, NC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part 1. Enter tije dis shock, or hear failu ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) theracleratio **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 ☐Yes 2 PNo 9 ☐ Unknown 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 6 Other (Specify) Hos/174 Nor7 Hu examiner's Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending

funeral director.

P.0. Division of Vital or Attending within 24 hours after death To the Funeral Director: filled in by completely

State

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

investigation

6 Could not be determined

MD 32. Registrar's Signature

Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

		1	For State Registrar	State of Marylani		tificate of t			eg. No. 200	35421
١	Physicia		1. Decedent's Name (First, Middle, Last Liliau	Mili	Ker			2. Date of Death	29, 2009	3. Time of Death 1:45 P M
-	/Medic Examin		4a. Facility Name (If not institution, give 204 GLENN ELLEN	street and number)		4b. City, Town, or	r Location of Death		4c. County of De	
	Funeral Director		5. Social Security Number 6. Se 214-90-8160		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12 - 17 - 1		irthplace (State or Foreign Country) MD
	Maryland a-f show		Usual Residence of Decedent 10a. State 10b. County MD BALTIMO		y, Town or Lo	cation ALTIMORE				10d. Inside City Limits 1 □Yes 2 ☑ No
	3a or 28	al Director	10e. Street and Number 204 GLENN ELLEN	CIRCLE		10f. Zip Code	21208	1	0g. Citizen of What C USA	Country?
036	irs a	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Ever in U. Armed Forcee? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🕅 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, ite, etc. WHITE
Maryland 21215-0036		Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired GISTERED	during most of work d)	ing	16b. Kind of Busines MEDICIN	
and 2	d be filed ental Hygi ced other c event, t	Be	17. Father's Name (First, Middle, Last) MARK	NISMAN			18. Mother's Nam	e (First, Middle, M	Maiden Surname) BELFER	
Mary	d 2 should th and Me 27 is mark traumati	욘	19a. Informant's Name/Relationship (7		19b. Mailii 204	ng Address (Street GLENN EL	and Number or Ru LEN CIRCL	ral Route Number E BALTI	, City or Town, State	, Zip Code) 21208
Baltimore,	Pages 1 an ment of Hea ant: If item 2 ury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State RAI	TIMORE		CEM. 11/0	1/2009	BALTIMORE	, MD
Balt	permit. Depart Import any Inj once.		21. Signature of Funeral Service Lio-	ruges.	89	000 REIST	ERSTOWN F	OAD PIK	N & BROS. (ESVILLE,	MD 21208
	rificate be executed Medical Examiner as the burial-transit	cal Examiner	23a. Part 1. Enter the disease, or composition shock, or heart failure. List only of the shock o	b. Due to (or as a consequence to (or as a consequence) C. Due to (or as a consequence) Due to (or as a consequence)	uence of): Hence of): Hal	ilune Care Care	cer	оттеарлаюту ат		Approximate Interval Between Onset and Death Zure & S Bruntys Bruntys Bruntys
O. Box	requires that the death certificat seen signed by the attending phy hould be detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩ No 9 □ Unknown	23c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of 9 Unknown	ıl death 3 l	□ Ectopic pregnand □ Other (specify) □	су		23d. Date of Month	delivery Day Year
ds, P.	signed by	þ	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	ınderlying cause gi	ven in Part I.	23e. Did to 1 □ Y		to the cause of death? Probably 4 Unknown
Vital Records,	The law ate has t page 2 si	Completed						24a. Was a autop perfor 1 □Yes	sy prior death	autopsy findings available to completion of cause of ?? 'es 2 \(\subseteq No
	Physician: Trithis certificatral director, pa	Be	25. Was case referred to medical examiner? 1 Yes 2 140	Hospital: 1 ☐ Inpatient 2 ☐	l ER/Outpatie	ent 3 DOA Ot	her:	th (Check only or	ence 6 ☐ Other (S	Specify)
on of	Attending Phys r death. ector: After this by the funeral di	tion: To	27. Manner of Doeth 1 Description 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	of 28c. Inju			ow injury occurred	
Division	after dear Director	Certification:	3 Suicide 6 Could not by determined		ome, farm, st	reet, factory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of my known in er: On the basis of examination and manner stated.	owledge, dea ation and/or i	th occurred at the nvestigation, in my	time, date and plac opinion, death occi	e, and due to the urred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	4. Sauce	in	29c. Licen	ise number	7992	29d. Date signed (M	onth, Day, Year)
	j		30. Harne and address of person who Edward A- 31. Date filed (Month, Day, Year)	completed cause of death (Ite	m 23a) (Type	Maylo	in TTZ	G. Grea	ine St E	BaltoMariro,
	Sta	ate	31. Date filed (Month, Day, Year)	2. Registrar's Sign	ature	wed)				

DHMH 17 Rev 1/2001

For State Registrar

1. Decedent's Name (First, Middle, Last)

Physician ALLAN S. **NO VOGRAD** 3:11 AM November 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Sinai Hospital of Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 08-06-1934 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** NY Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 273 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, in the fact than instead or other traumatic event. 1 X Yes 2 □ No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3205 PINKNEY ROAD USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 💢 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: <u>Ş</u> WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) **BROKER** INSURANCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FINGERUT J0EL **NOVOGRAD** ပ SADIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SHIRLEY NOVOGRAD/WIFE 3205 PINKNEY ROAD, BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CHEVRA AHAVAS CHESED 10-02-2009 RANDALLSTOWN. MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Acute Myccardial disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Atherosclerotic Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit P.O. Box 68760,€ Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, icate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital of Baltimore McCinley M.D.
32 Registrar's Signature Patrick 31. Date filed (Month, Day, Year) State NOV - 4Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #20b, perFh g897 11/4/09 TT State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

35422

Reg. No 2009

Ye ar

Day

2. Date of Death

Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 35423 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** O'Toole October 30, 2009 James Lawrence 9:50 p. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4408 Dresden St. Montgomery Kensington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 92 1 5 M 2 □ F 169-09-9711 Feb. 6, 1917 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Montgomery Kensington 1 ☐Yes 2 ☐No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20895 4408 Dresden St. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examination. 1 ⊠Yes 2 □ No If Yes, Give WW Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: White Specify چ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Manager Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Austin O'Toole Mary Kelley ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean O'Toole (wife) 4408 Dresden St. Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov. 2009 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, Maryland 20910 KAN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Coronary Artery Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Dementia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami Diabetes Mellitus II Due to (or as a consequence of): Completed by Physician/Medical Hypotension 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Dav 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐ Yes ŽŽNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 2, 2009 D18813 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) 10301 Georgia Ave. Suite 304 Silver Spring, MD 20902 Ira Tauber, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MOV 0 4 2009 Registrar ark

death with the Maryland

Baltimore, Maryland 21215-0036

ral", or items 23a or 28a-f show Exa⊤ingr must be notified at

physician and the burial-tran

signed by the attending place as the detached for use as

certificate has been s irector, page 2 should

After this

after death

24 hours

To the Hosp within 24 hor To the Fune completely fi

10+1

filled in by the funeral

Division of Vital Records, P.O. Box 68760,

or Attending Physician:

JAMES O'TOOKE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	State of Maryland / Department		lental Hygie	ene	051.01				
			1. Decedent's Name (First, Middle, Last)	tificate of Death	T	. No. 2 1 1 9	35424				
	Physicia		Patricia M. O'Neill		2. Date of Death	Day 2009	3. Time of Death				
н	Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	October	4c. County of Death	10.10				
		•	Union Memorial Hospital	Baltimore		N/A					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birthp	lace (State or Foreign				
Н	Director		215-28-2734 1 1 M 2 M 7 7 Yrs. Usual Residence of Decedent		Feb. 16.	1932 Mary	land				
	nd how at	٦	10a. State 10b. County 10c. City, Town or Loc	cation		10	0d. Inside City Limits				
	laryla 3a-f s iffied	Director	Maryland Anne Arundel Pasadena				1 ☐ Yes 2 🗷 No				
	or 28	₫	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Count	try?				
	The second state of the specific Cultar Mexican Puerto Rican etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes specify Cultar Mexican Puerto Rican etc.) 14. Race - Amerita Force?										
	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amer Black, White										
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15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Gleve kind of work dane during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Gleve kind of work dane during most of working life. DO NOT use retired)											
212	withir giene er th		9	Homemaker		Own Home					
pu	filed tal Hy d oth	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Mai	den Surname)					
yla	uld be Men narke natic	1	Francis Malone	Muriel	Sau						
Nai	shorth and 1.7 is r			g Address (Street and Number or Rura							
e,	and 2 Healt tem 2 ther		Anthony F'. Tinelli (son) 380 1 20a. Method of Disposition 20b. Place of Dispo	Hunner Road, Pasac		YIANG ZIIZZ Oc. Location - City or Tox					
nor	age 1 ent of nt: If i		1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State cemetery, crem	natory or other place)							
altir.	nit. Partme		1 illicities C	rematory, Inc. 11/02 Name and Address of Facility		en Burnie, Ma	Lyland				
ñ	permi Depar Impor any ir		MZU 32	McCully—Polyniak Fune 04 Mountain Road, Pas	ral Home P. adena, Mary	and 21122					
			23a. Par 1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.				Approximate Interval Between				
	Physician/		Immediate Cause (Final disease or condition Mesenteric	Ischemia		16	Onset and Death				
	Medical Examiner		resulting in death) Due to (or as a consequence of):	2 12 19 000 1	\ A_ 15:	,					
E	Lammer	r.	Sequentially let conditions, b Schemic C	Schemic Cardiony pathy Due to (or as a consequence of):							
_	sit ed	dical Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Laton Nicea	CP '	1) n Known				
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09	cate be executed physician and s the burial-transit	ical	d								
376	ficate g phy as the	Med	- 5			1					
30 30	endin use	an/h	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	Ectopic pregnancy		23d. Date of delive					
Box 687	death	Physician/Me		Other (specify)	₹	Month	Day Year				
o.	at the		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e Did tobar	cco use contribute to the	e cause of death?				
Division of Vital Records, P.O.	es tha signer I be d	d by		,g g		2 □ No 3 □ Prob	. /				
ğ	requil been should	Completed			24a. Was an		sy findings available				
ecc	e law e has l ge 2 s	duo		.	autopsy performe	prior to cor death?	npletion of cause of				
<u> </u>	in: Th ificate or, pa		25. Was case referred to medical	26. Place of Death (Chec	1 Tes 2 k	No 1 Yes	2 No				
Vita	ysicia s cert direct	To Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatien	Other		ce 6 Other (Specify)					
of	ng Ph ter thi neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of (Month, Day, Year)	28c. Injury at work?	28d. Describe how						
ion	tendir eath. or: Af the fu	ifica	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No							
Vis	or Att	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,				
	pital ours a eral [29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of	occurred at the time, date and place, as	nd due to the cause	(s) and manner as state	1				
(To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnal-transit	Medical	(Check 2 Medical Examiner: On the basis of examination and/or invest only one) 3 Certifying Nurse Practioner: To the best of my knowledge, or	igation, in my opinion, death occurred a	t the time, date and p	place, and due to the cau	se(s) and manner stated.				
	To the vithing to the complex		29b. Signature and title of certifier	29c. License number		I. Date signed (Month, E	Day, Year)				
	_		Alle m.p.	AT243894	6 1		009				
	,		30. Name and address of person who completed cause of death (Item 23a) (Type, F	EMORIAL HOSPITA	AT DAIT	MADAR M	(D21218				
	Sta	e	DIAJA EL-MITOV HEI UNION M 31. Date filed (Month, Day, Year) 32. Registrar's Signature	as	14 137011	700700	*				
	Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	A SOUTH AND A SOUT							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #2 Per MD 9897 11/4/09 TT
State of Maryland / Department of Health and Mental Hygiene State Amend #11 & 19a, per Fh g897 11/10/09 TT Registrar

For Englishman Amend #11 & 19a, per Fh g897 11/10/09 TT Death Reg. No. 2009 35425 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11/1/2009 **Physician** artiet 10:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BaHIMOre If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 2 2 5 Social Security Number Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) 1**X**M 2□F Months Days Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show at KaltiMore 1 Yes 2 No be notified MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō USA or items 23a Laurelton must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Completed by Specify: 3 2 Widewed 4 □ Divorced "natural", Black er than "natur, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel 7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type Print) ACYNTHIA FATTIET Johnson permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Daughter JaHIMOYE, Maryland 21214 nul 20b. Place of Disposition (Name of Acemetery, crematory or other place) Method of Disposition Date - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HOWHILS 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility MO1553 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) REBROUDSCUL **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for se a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□tinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes page 2 should Completed certificate has been 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? 1 Yes 2 □ No 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ASSIM Other: 4 Nursing Home 5 Residence 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 6 Other (Specify) TAING filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c License number 29d. Date signed (Month Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (6 PARK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2009 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death Year 09 Month Physician avence 2:35 PM Kideou /Medical 4c. County of Death Facility Name (If not institution, give s 4b. City, Town, or Location of Death Examiner HaltiMore Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it a Medical Examitation in the routified at 1 Yes 2 No Baltimore Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Glenkirk Road 21234 12. Was Decedent Ever in U.S. Armed Forces? 1 M/Yes 2 □ No IM/es, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Completed by 3 ¥ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rideout unknown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Batimore, Maryland Francine Boyo Department of Health a Important: If item 27 Is any Injury or other tra once. Kead 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Servi mo155 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ZNO '04RS Physician WEMETIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MNUTRITION Sequentially list conditions, if any, leading to mineriale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to (or as a consequence or, 2000 To the Hospital or Attending Physician: The law requires that the death certificate be executed FERUSCIERUTIC attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: A A 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year in the past 12 months?
1 □ Yes 2 □ No Month Day 5 ☐ Other (specify) 4 Pregnant at time of death P.O. 9 Unknown signed by the period of the pe 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 Probably 4 Unknown 1 Yes certificate has been si rector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide lace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signaturé

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marlene M. Reisinger Dav Year 12:00p M 10/30/09 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1465 Towson Street Baltimore N/A Social Security Number . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-42-8943 1 M 2 CXF 65 Months Days Hours 6/12/44 Year Director MD Usual Residence of Decedent 28a-f shov 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits by Funeral Director MD N/A Baltimore City 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1465 Towson Street 21230 USA . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes Give white Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Machine Shop Office Manager 12 2 Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Elmer E. Bruce Eileen J. Wright 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1465 Towson Street, Baltimore MD 21230 Leroy F. Reisinger / Husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 11/3/09 Baltimore Maryland 4 Donation 5 Other (Specify) Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 21. Signature of Euneral Service Licensee), w 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam ed by the attending physician and detached for use as the bunal-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregna☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year g Unknown 9 Unknown P.O. F After this certificate has been signed by a funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No I or Attending Physician: Tafter death.
Director: After this certifice Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 1 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur and title of certifie 830 Vovember

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) larles

32. Registrar's Signature

NOV 0 4 2009

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

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Mag.	Physici /Medic Examin	an cal er	1. 4a.
	Funeral Director		5. 9
Daltillore, Maryland 21219-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Iha Medical Examiner must be notified at once.	To Be Completed by Funeral Director	100 V
اما	12 shouth and № 7 is material	_	19 Ve 20:
1014	ages 1 and ant of Heal t: If item 2 y or other		20:
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i			23
	Physician /Medical		Im di: re

1 Burial 2 □ Cremation 3 □ Removal from State 109 Quantico National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility obest B Bal mediate Cause (Final cat rain sease or condition sulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner StreptoCoCCUS

Due to (or as a consequence of): neumonia Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 1 □ Yes 25. Was case referred to medical examiner? Be 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 X Inpatient 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number manier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kahmanian 1500 Forest Glen Road Silverspring, MD 20910 Majid

32. Registrar's Signature

Decedent's Name (First, Middle, Last) 2. Date of Death Day 5:30 PM 30, ar 2009 Chiber Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomer Silver Spring 0 Hospita If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year Days Hours 1 X M 2 F Months 28-78-50ZZ 55 January 18, 195 ira inia sual Residence of Decedent a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits lexandria 1 ¥ Yes 2 □ No irginia e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 22301 Raymond 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Marital Status Black, White, etc. If Yes 2 □ No
If Yes, Give 10/9/15-6/29/80
Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 K No Specify: Slack 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Real Estate C state Agent Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Saunders ernell James a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Raymond Ave. Alexandria, Virginia 22301 ernell J. Saunders -Mother 318 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State a. Method of Disposition Virginia Triangle, Chinn Funeral Service 2605 S. Shirlington Real Arkington, Va. 22206 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No 2 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this 28d. Describe how injury occurred 24 hours after deat Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 27,2009 October Mary Jane Stolworthy 5:11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9109 Lincolnshire Court Apt.K Parkville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 86 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Months Days Hours Director December 5,1922 Washington, DC 217-14-7835 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f show Md. Balto. Parkville 1 ☐ Yes 2 1 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9109 Lincolnshire Court 21234 USA Apt.K 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No Specify. þ White 3 ☐ Widowed 4 🌠 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be fill truent of Health and Mental Flant: If item 27 is marked of Ernest C. Clifford Nellie G. O'Blenis P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other: other 3820 Perryhurst Place Nottingham, Md. 21236 <u>James Boyer</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 10-28-2009 4 ☐ Donation 5 ☐ Other (Specify) Bavview Balto. Md. 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee 11 9705 Belair Rd. Nottingham, Md. 21236 23a. Pert 1. Enter the disease, or complications that conted the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or lach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hal 919 morth /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>^</u> 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No al or Attending Physician: 's after death.'
I Director: After this certifice 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 ☐ Homicide within 24 hours a the Hospital 29a. Certifier f 🔀 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number (0 MD ne and address of person who completed cause of death (Item 23a) (Type, Print) 436 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

21215-0036

Baltimore, Maryland

Box 68760.

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Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10d, per Fh 9897 11/4/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 2009 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death

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Physician /Medica Examine

Funeral Director

Benton

schwort,

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Modical Evantical must be notified at once.

Physician /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 5

an	1. Decedent's Nam	ne (First, Middle,	, Last)				2. Date of Death Anoth Day Year 3. Time of Dea					
an cal	B	ENTON		SCHWAR	TZ		October	30 200	9 4:00 PM			
er			give street and number)		4b. City, Town, o	r Location of Death	1	4c. County of De	eath			
	5. Social Security N		AVENUE, #50		BALTI				IMORE			
	216-34-4	094	6. Sex 7. Ag	72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/09/1	9. E 936	lirthplace (State or Foreign Country) MD			
	Usual Residence of 10a. State	10b. County		10c. City, Town or Loc	eation				10d. Inside City Limits			
jo	MD		IMORE		TIMORE				TXTes 2X No			
rec	10e. Street and Nu			51,12	10f. Zip Code		10	g. Citizen of What (Country?			
al D	1500 B	EDFORD A	AVENUE, #50	7		208			USA			
iner	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S. 13. V	Vas Decedent of H	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-	14. Race - Ar	nerican Indian,			
Be Completed by Funeral Director	1 ☐ Never Marr 3 ☐ Widowed		lf Yes, Give Year or Dates:	No	□Yes 2XNo	Specify:	Black, Wh					
ted		15. Decedent's	Education	16a. Deced	ent's Usual Occup	pation	1	6b. Kind of Busines				
ple	Elementary/Seco	cify only highest	grade completed) College (1-4or 5	(Give)		durina most of worl	ob. Tand of busines	3/muusti y				
Som	Liementary/3600	midaly (0°12)	College (1-46r 8	MAN.	AGER			MARYLAND	CUP			
Be (17. Father's Name	(First, Middle, L	•			18. Mother's Nam						
မှ	JACK			SCHWARTZ			INETTE		CHLESS			
		19a. Informant's Name/Relationship (Type. Print) FLORINE ZESKIND / SISTER 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State 5134 WAGON SHED CIRCLE, OWINGS MILLS, M										
	20a. Method of Disp		B ☐ Removal from State	20b. Place of Dispos	sition (Name of	i		0c. Location - City of				
	4 ☐ Donation	5 ☐ Other (Spe	ecify)	BETH ISR	AFI	11/02	/2009	BALTI	MORE, MD			
	21. Signature of Fu	1. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BRO 8900 REISTERSTOWN ROAD, PIKESVILLE,										
	23a Part 1 Enter ti	he disease or c	omplications that caused	the death. De not ente	The mode of the	IERSTOWN	ROAD, PI	KESVILLE,				
	shock, or hea	it laliule. List of	nly one cause on each lin	ie.				st,	Approximate Interval Between Onset and Death			
	disease or conditio resulting in death)		-a. atherosc	lerotic Ca	rdiovasc	illar d	isease					
			Due to (or as	a consequence of):								
ner	Sequentially list cor if any, leading to im	mediate	b. Due to (or as	a consequence of):								
ami	cause. Enter Unde Cause (Disease or that initiated events	injury	. hyper	lipidennia								
cian/Medical Examiner	resulting in death) L	_ast	Due to (or as	a c nsequence of):								
dice			d									
/Me	IF FEMALE:		23c. If yes, outcome	of pregnancy				004 0-4-44				
iciar	23b. Was decedent in the past 12 1 ☐ Yes 2 ☐	months?	1 ☐ Live birth 4 ☐ Pregnant at	2 ☐ Fetal death 3 ☐ time of death 5 ☐	Ectopic pregnanc Other (specify) _	<i>y</i>		23d. Date of d Month	Day Year			
hys	9 ☐ Unknown	3110	9 ☐ Unknown		,,							
Be Completed by Physic			s contributing to death bu		derlying cause give	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?			
ted	<u>chron</u>	1c rem	al tailure				1 ☐ Yes	2 □ No 3 □ I	Probably 4 Unknown			
n ple							24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of			
င်							performe	ed? death?	s 2□No			
	25. Was case referr examiner?	/	Hospital:		Oth		h (Check only one)					
<u>۹</u>	1 Yes 2 Nanger of Death	_	1 ☐ Inpatie	nt 2 ER/Outpatient y 28b. Time of		4 LI Nursing Ho		ce 6 Other (Sp	ecify)			
atior	1 Natural 2 □ Accident	5 Pending investigat	(Month, Day	(, Year) Injury	28c. Injur Work M 1 🗆	yai ? Yes 2□No	28d. Describe how	injury occurred				
Įį į	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine		ry - At home, farm, stree	et, factory, office		28f. Location (Stre	et and Number or F	Rural Route Number,			
Č		_/	3			<u> </u>	City or Town,	ŕ				
Medical Certification: To	29a. Certifier (Check only one)	12 Certifying 2 Medical Ex	Physician: To the best of caminer: On the basis of and manner sta	examination and/or inve	occurred at the tirestigation, in my o	ne, date and place, pinion, death occur	and due to the cau	use(s) and manner e and place, and du	as stated. le to the cause(s)			
Mec	29b. Signature and t	title of certifier	and manner sta	ieu.	29c. License	e number	290	d. Date signed (Mor	oth, Dav. Year)			
D539							and ball ball and (mornin, bay, roar)					
	30. Name and addre	ess of person wh	no completed cause of de	eath (Item 23a) (Type, P			U	CIDE J	, , , , ,			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ellie P. Goldbloom, MD 21 Crossmads Drive #400 Owings Mills, M.								MD 21117				
	31. Date filed (Monti	h, Day, Year)	32. Registra	r's Signature				,				

State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend item 10d per fh 8897 11-4-09 vt. State of Maryland / Department of Health and Mental Hygiene 2009 35432 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** GRIMES November 14 ×32 PM VICTORIA TALLE SLENDA 01 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town or Location of Death 4c. County of Death Examiner Muspita Baltimore gres If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 216-36-8176 **Director** MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. Internation of them 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar mast be mortified at 1 € Yes 2 ▼ No Director MARYLAND BALTIMORE BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 U.S.A. 2500 Cheshaire Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify þ Specify: BLACK 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RAYMOND ပ CROSS DOROTHY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau ENETTE GRIMES (DAUGHTER) 3445 KOUND ROAD, BALTIMORE, MD 21925 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State GARRISON FOREST CEM: 11/12/2009 DWINGS MILLS, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME Illiams 240 N. FULTON AVE, BALTIMORE, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia Physician disease or condition resulting in death) days /Medical Due o (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tra use as the burial-trai that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Kidney disease 2**X** No Completed 1 🗌 Yes 3 Probably 4 Unknown cerebra vascular disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 25. Was case referred to medical examiner? 2 **X**No with 1 □Yes 1 ☐ Yes Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death
1 Natural
2 Accident funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the t 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 23496 November 01

State Registrar

Division of Vital Records.

Caton

Avenue

900

Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ang 32.

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Ming -Hs
31. Date filed (Month, Day, Year)

NOV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year Gladys Taylor 0350 4 9009 November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner TA 19170-1361 Bel Air Harford 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05-03-1920 Birthplace (State or Foreign Country)
 VA 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 💢 F 89 Director 225-18-9765 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f show 10d. Inside City Limits Director Harford 1 ☐ Yes 2 No MD Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2208 Brookhaven Court 21047 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item any injury or other traumatic event, it is Medical Exaci 1 Never Married 2 Married A lady 3 1 ay lot Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates Specify. <u>\$</u> Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Hood 2 Lucretia Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Fox (Daughter) 2208 Brookhaven Ct Fallston, MD 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 A Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Dryden Cemetery 11-05-2009 | Dryden, VA 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee 610 W. MacPhail Rd BelAir, MD 21014 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician FAILURE TO disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 physician Physician/Medical the attending pl IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 TNo Month Year Day 5 Other (specify) P.O. | detached 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ CHRONIC ANEMIA 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No CULAR DISEASE 24a. Was an has autopsy certificate performed' osteo authoritis 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) 1 Tes 2 MNo Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural death. 2 Accident 1 ☐ Yes 2 ☐ No the Funeral Director: filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 24 29b. Signature and title o 29c. License number

State Registrar

SUKESH 31. Date filed (Month, Day, Year)

0

622 S. UNION AVE, HAVRE DEGRACE, MD 21078

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas	se Type or Pr									ible.		
	•	For State Registrar		State of iv	ıaryıarı		artmen <i>tificate</i>			Mental Hygiene Reg. No. 2009 354					434
Physicia	n/	1. Decedent's Name		Last) Teclaw						2. Date of De Month	ath			3. Time of	Death
Medic Examin		4a. Facility Name (if	not institution,	give street and number)					Location of Death	Novemb	or Day 1, 2009 7:07 A M 4c. County of Death			ΑM	
Funeral		5. Social Security No	christ 1	6. Sex	ne (In vrs. la	Towson (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.				8. Date of Bir		Balt		place (State or	r Foreign
Director		326-58-16	601	1 [M 2 [X] = [64	Yrs.	Months	Days	Hours Min.	$\operatorname{Aug}^{Month,Pa}$	y, Year	45	Coun		_
th with the Maryland ms 23a or 28a-f show must be notified at	. 1	10a. State	10b. County	1	10c. City	y, Town or Loc	ation kers	-211.	-				1	0d. Inside Cit	y Limits
the Mar or 28a e notifi	Funeral Director	Maryland 10e. Street and Num		erick		Wal	10f. Zip				109. 0	itizen of V	Vhat Cour	1 🗌 Yes	2 X No
th with ns 23a must b	nera	8617 Disc	covery						21793			nite	d Sta	ates	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status1 ☐ Never Marri3 ☐ Widowed		12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		1			spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)			e - Americ k, White, e		
72 hour	Completed			t grade completed)			ind of wor	k done d	ation Juring most of work	king	16b.	Kind of Bu	isiness Inc	dustry	
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uld be filed Mental Hy narked otl	To Be	17. Father's Name (F Noel Bace	ou1a						18. Mother's Nam Azniv	ne (First, Middle, e Sahak:		n Surname) 		
and 2 shou Health and Im 27 is n her traum			1aw / S			1208	Runny	mede	Lane, E						
Page 1 ament of Hant; If ite		20a. Method of Disp 1 X Burial 2 Donation	Cremation 3	3 ☐ Removal from State		Place of Disposemetery, crema ade Cen	atory or o	ther place	11/4		Wal		ville	, Mary	land
permit Depart Import any inj once.		21. Signature of Fun	neral Service Lid	Stauller		22.			s of Facility Sosumtown	tauffer Pike,					2
Dhyminian (23a. P. 1. Enter the shirt, or hear Immediate Cause (F	t fail 🚾 List on	complication t cause aly one cause on each lin	e.			of dying	g, such as cardiac	or respiratory an	rest,			Approximate Interval Betw Onset and D	veen
Physician/ Medical Examiner		disease or condition resulting in death)		a. Moltin Due to (or as			na				_		+	year.	?
d sit	Examiner	Sequentially list conditions, if any, leading to immediate Cause Fit at Underlying Cause (Disease or injury)													
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ificate be exe ng physician as the burial-	Medic	F FEMALE:		d							_		\perp		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu		23b. Was decedent in the past 12 n 1 Yes 2 X 9 Unknown	ponths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	I death 3 🗌	Ectopic p Other (sp		/			23d. Date Mor	e of delive		ear
uires that the signed by the detail		~		is contributing to death to		_		,						e cause of de	
The law rec ate has bee page 2 sho	Completed by			3						24a. Was autop perfo 1 Yes		l p		osy findings ampletion of ca	
sician: certific irector,		25. Was case referre examiner? 1 Yes 2		Hospital:				Other	ce of Death (Chec	k only one)					
nding Phy ath. :: After this e funeral d		27. Manner of Death 1 Natural 2 Accident		28a. Date of inju (Month, Da	ıry	ER/Outpatient 28b. Time of injury		Bc. Injury work?	t 4 □ Nursing Hotat	ome 5 L. Resid				HOA!	<u>Co</u>
al or Atte s after des I Director ed in by th	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ot be			et, factory,	office		28f. Location (S City or Tow			r or Rural	Route Numbe	er,
he Hospit in 24 houn he Funera pleted fille	Medical	29a. Certifier 1 (Check 2 only one) 3	Medical Exa	Physician: To the best of aminer: On the basis of e Nurse Practioner: To the	xamination	and/or investi-	ation, in n	ny opinion	n, death occurred a	t the time, date a	nd plac	e, and due	to the cau	se(s) and man	iner stated.
To the To the COTH		29b. Signature and ti		12177200x (CNF)	29c.	License			29d. Da	ate signed	(Month, E		3
PV	;	Name and addre	ess of person wh	no completed cause of d	- <t+ -<="" th=""><th>TOUSO</th><th>int)</th><th></th><th>Blud 7</th><th></th><th></th><th>-</th><th>1000</th><th></th><th></th></t+>	TOUSO	int)		Blud 7			-	1000		
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DHMH 17 Rev 7/2009

			1 - For State Registrar	State of Maryland / Dep	ertificate of Death		ene g. No. 2009	35435
	Physici /Medic		1. Decedent's Name (First, Middle, Last, REGINALD	HORNTON		2. Date of Death Month	Day Year 31 2009	3. Time of Death
1	Examir Funeral		4a. Facility Name (If not institution, give UNIVELS TY OF MAM 5. Social Security Number 6. Set	LAWD MEDILYSL (ENTER	4b. City, Town, or Location of Dea RALT W b LE If Under 1 Year If Under 24 Hrs Months Days Hours Min	8. Date of Birth	Year Count	ace (State or Foreign
	Director show	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		58	d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th with the N 23a or 28a-i ust be reath	ral Director	10e. Street and Number 5001 Corley Ro	1110	10f. Zlp Code 21207	100	g. Citizen of What Countr	
9036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examenate Legaling at	d by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Everin U.S. Armed Forces? 1	Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 MNo Specify:	Specify Yes or No- to Rican, etc.)	14. Race - America Black, White, et Specify: Bla	
21215-0036	id within 72 ha rgiene. er than "natu i, the Medical	Completed	15. Decedent's Edu (Specify only highest grade	College (1-4or 5+) (Given life.	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired) INTENANCE 1EC	rking 10	6b. Kind of Business/Indu	asement
Maryland	should be file and Mental Hy s marked oth umatic event	To Be	17. Father's Name (First, Middle, Last) Seorse Thorn 19a. Informan ame/Relationship (Ty		18. Mother's Na 18. Mother's Na ing Address (Street and Number of Fi	me (First, Middle, Ma	Ker	Code)
altimore, Ma	is 1 and 2 of Health item 27 l		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	hornton Wife 500 20b. Place of Disp	osition (Name of matory or other place)	Apt. 8 E	Bc.Ho.MD 2 Oc. Location - City or Tow	1207
Baltii	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	Gere 3	22. Name and Address of Facility (a. 515) Bayto. M		Parto, m	baldag
	Iticate be executed /Medical Examiner sthe burial-transit	edical Examiner	shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to indirectiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	CHALLE (STALE)	320		Approximate Initerval Between Onset and Death
O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliver Month	y Day Year
rds, P.	w requires that to be by should be detact	þ	Part II. Other significant conditions cor	tributing to death but not resulting in the t	underlying cause given in Part I.		acco use contribute to the	
Division of Vital Records,	ician: The law re certificate has be ector, page 2 sho	Completed	25. Was case referred to medical			24a. Was an autopsy perform 1 □ Yes 2	prior to com death? ■No 1 □ Yes 2	sy findings available pletion of cause of
5	ysicia is cert directe	To Be	examiner?	ospital: 1 Inpatient 2 □ ER/Outpatie	4	ath <i>(Check only one)</i> Home 5 □ Residen	oce 6 ☐ Other (Specify)	1
_ _	ing Phy Viter thi uneral	On: T	27. Manner of Death 1 💆 Natural 5 🗌 Pending	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	of 28c. Injury at Work?	28d. Describe how		
DIVISIO	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	M 1 □Yes 2 □No	28f. Location (Stre City or Town,	eet and Number or Rural State)	Route Number,
/	n 24 hour n 24 hour ne Funera pletely filli	Medical (29a. Certifier (Check only one) 1 ☑ Certifying Phys 2 ☐ Medical Examin	ician: To the best of my knowledge, dea er: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place investigation, in my opinion, death occurred.	e, and due to the car urred at the time, dat	use(s) and manner as state and place, and due to	ated. the cause(s)
	To the	W	29b. Signature and title of certifier Kennth D. C	d. Date signed (Month, D	ay, Year)			
			30. Name and address of person who co		Print) 22 S. Green	a ct R.U	1 MD 71	701
ı	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	0.000	2 - Dal	יוין בוסאניו	

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Frace	e Tyler		1- For State Registrar	State	of Maryland		irtment of <i>tificate of</i>			Viental H		eg. No.	109	35436
	Physicia	an/	Decedent's Name	(First, Middle,La	st)	-					2. Date of Dea Month Novembe			Time of Death 1450 hrs
vied	ical Exami	ner	Grace 4a Facility Name (if I	Tyler	ve street and number)		Ţ.	4b. City, T	own, or Loc	ation of Deat		4c. County o		
1			4721 Plesant						erstown			Baltimore		´
	Funeral Director		5. Social Security Nu 218-12-4		бех 7. Ag	e (In yrs. Ia	ast birthday) Yrs	Month		f Under 24Hr Hours Mir		th(MM/DD/YYYY 4 9,1919		lace (State or Foreign ry) yland
	ķ	ļ	Usual Residence of I	Decedent 0b. County		10c City	Town or Locat	tion						Od. Inside City Limits
	iow any		MD	Ba1t:	imore		eister		7n				1	Yes XX No
	aryland 8a-f show at once,	Director	10e. Street and Num	_				10f. Zip			11	10g. Citizen of Wh	at Country	?
	th the Maryland 23a or 28a-f sho notified at once.	ğ	4721 P	leasant	t Grove 1	Rđ.			211	36	-	U.S	. A.	
	e, MD 21215-0036 land 2 should be filed within 72 hours after death with the Maryland Haelth and Mental Hygiene and Anthon 1, or items 23a or 28a-f sho item 27 is marked other than "natural", or items 23a or 28a-f sho r traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married		1 Yes 2		If Y	es, specif	y Cuban, M	exican, Puert	pecify Yes or No o Rican, etc.)	White		n Indian, Black,
	rs afte ural", miner	Š	XX Widowed	4 Divorce	d If Yes, Give Year or Dates: only highest grade con	npleted)	16a. Deceder		X No s		work done	Specify: 16b. Kind of Bu		
	5-0036 led within 72 hour Hygiene. other than "natt	Completed	Elementary/Secon		College (1-4 or		during m	nost of wor		NOT use re		I	n Ho	
	5-0036 led within 7 Hygiene l other than the Medica		17. Father's Name (F	irst, Middle, Las	t)				18.1	Mother's Nam	e (First, Middle,	Maiden Surname	j	•
	2121 uld be fil Mental F marked c event,	Be	unknot 19a. Informant's Nan		Gutmar Type Print	<u> </u>	19h Mailin	a Address	(Street ar	Mary		unkno mber, City or Tow		in Code)
	MD 21 d 2 should th and Mei n 27 is mai	우	James F.			n		•						n, MD21136
	re, ME s 1 and 2 s f Health a If item 27		20a. Method of Dispo	osition		20b. I	Place of Dispos crematory or ot	sition (Nar	ne of cemete		Date	20c. Location -		
	Pages lent of ant: If or other			Other Specif	Removal from St	ate	tro Cre	emat	ory I	nc. 1	1/3/09	Baltin	nore	, MD
	Baltimore, permit. Pages I as Department of He Important: If ite injury or other the		21. Signature of Fun	eral Service Lice	ensee									pel P.A. 1s,MD2111
			23a. Part I. Enter the	disease, or com	iplications that caused	the death						_	art	Approximate Interval
8	Physician		failure. List only Immediate Cause (F	one cause on e	each line. Atherosclerotic									Between Onset and Death
	aminer		or condition resulting		Due to (or as a cons									
		L	Sequentially list con if any, leading to imr		Due to (or as a cons	equence o	f):						-	
		Examiner	cause. Enter Under	lying Cause	6						<u>.</u>			
	ted J unsit	Exa	events resulting in d		Due to (or as a cons	equence o	1):							
4,	50, te be executed tysician and burial - transit	Nedical	UNPENDED		V AMENDED	- 1711	0011 1	120.11	2011 7	IC.				
	760, cate be exe physician he burial -	Med	IF FEMALE:		23c. If yes, outco	me of preg	.G911.1 nancy	1281.	, many			23d. Date of		
	Sox 6876 Jeath certificate e attending phy for use as the	ian/	23b. Was decedent p past 12 months?		1 Live birth Pregnant a	t time of de	oth	etal death other (Spe		Ectopic pregr	nancy	Month	Day	y Year
	Box 687 e death certifice the attending p ed for use as th	Physician/N	1 Yes 2 ✓ N	o 9 Unknow	vn 9 Unknown		<u> </u>	ittler (ope	ony)					
	P.O. B es that the digned by the detached	by PI	Part II. Other signifi		contributing to deal	th but not r	esulting in the	underlying	cause give	n in Part I.		tobacco use contr		e cause of death?
	cords, P.C law requires that has been signed b	ted t	Alzheimer's	Disease		_					. 24a. Was	7 2212		osy findings available
	cord law rec has bee 2 shou	Completed			<u> </u>				_		auto	psy r		npletion of cause of
	tal Rection: The certificate ector, page		OF Management	ad to modical					26 Place of	Death (Check		2 No 1	Yes	2 No
	/ital	Be c	25. Was case referred examiner? 1 ✓ Yes 2	No	Hospital: 1 Inpati	ent 2	ER/Outpatien					Residence 6	Other: §	Scene
	1 of Vital Rec ling Physician: The l After this certificate l funeral director, page	n: To	27. Manner of Death		28a. Date of Inj (Month, Day,	ury Year)	28b. Time of	Injury	28c. Injury a	_	28d. Describe	how injury occurr	ed	
	ttendin Jeath. Stor: /	atio	1 V Natural 2 Accident	5 Pending Investiga	ation					2 No				
	Division of Vital Records, pital or Attending Physician: The law require and a start death.	Certification:	3 Suicide	6 Could no determin		njury - At h	ome, farm, stre	eet, factory	, office build	ding, etc.	28f, Location or Town,		er or Rura	Route Number, City
Λ	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 butous after death. To the Functal Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		4 Homicide 29a. Certifier (Check only one)	Certifying Physi	ician: To the best of n	ny knowled	lge, death occu	urred at the	e time, date y opinion, de	and place, ar	nd due to the cau I at the time, date	use(s) and manner	as stated	cause(s)
1	To t To t	Medical	29b. Signature and		and manner stated				c. License n			29d. Date sign		
1			(ar	al H	allow	_			O.C.M.	E.		November	3, 2009	
			30. Name and addre		o completed cause of tant Medical Exa		111 Penn	Street,	Baltimore	e, MD 212	01	- L		
		tate	10. 10	h, Day, Year)	nna l	ar's Signat	ure da	Rod						
	Regis	uar	N	U	UUJ Lener	~ /	A . MA	-						

ink Toland		State of Maryland / Department of In-For State Certificate of In-For State Registrar	Death	Reg. No. 2009 3543			
Physiciar edical Examin		1. Decedent's Name (First, Middle,Last) Frank Edward Toland	2. Date of I Month Novem	Death Shape Pear Day Pear Day Pear 1, 2009 3. Time of Death 1031 hrs			
		4a. Facility Name (if not institution, give street and number) 4b. Bon Secours Hospital	D. City, Town, or Location of Death Baltimore	4c. County of Death N/A			
Funeral Director		5. Social Security Number 2 1 2 - 4 2 - 5 1 2 2 6. Sex 6 4 7rs.		Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign S. Caroli			
any	F	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locatio	0	10d. Inside City Limits			
* .	_	Maryland N/A Baltimo		1 X Yes 2 No			
the Maryland a or 28a-f show			10f. Zip Code 21 22 9	10g. Citizen of What Country? USA			
	Fune	1 Never Married 2 Married Armed Forces? If Yes	Decedent of Hispanic Origin? (Specify Yes or s, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 X No specify:				
36 in 72 hours af han "natural dical Examin	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's	s Usual Occupation (Give kind of work done st of working life. DO NOT use retired)	16b. Kind of Business/Industry Southern Galvaniz- ing Co.			
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medical	Be Com	17. Father's Name (First, Middle, Last) Earl Toland	18.Mother's Name (First, Midd Gladys Whi	dle, Maiden Surname)			
MD 21 d 2 should 1 Ith and Mer n 27 is mar		Gladys Toland/ Mother 1013	-	Baltimore,MD 21229			
Baltimore, lermit. Pages I and Department of Heal Important: If item injury or other tra		1 Seurial 2 Cremation 3 Removal from State crematory or other	ion (Name of cemetery, 11/7/09 dge Cemetery	20c. Location - City or Town, State Pikesville, MD			
Balti permit. Departm Imports injury o		21. Signature of Funeral Service Lensee 22. Na 52	40 Reisterstown R	n-Harris Funeral Hom d Baltimore,MD 21215			
Physician /Medical *xaminer		23a. Pal. I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Stomach Cancer with Complications or condition resulting in death)		y arrest, shock, or heart Approximate Interval Between Onset and Death			
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Lines Unidenlying Cause (Disease or injury that initiated					
xecuted n and l - transit	cal Exa	events resulting in death) Last Due to (or as a consequence of): d. UNPENDED AMENDED					
ox 6876 ath certificat attending ph or use as the	sician/I	23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetz	al death 3 Ectopic pregnancy er (Specify)	23d. Date of delivery Month Day Year			
ires that the de signed by the	<u>۾</u>	Part II. Other significant conditions contributing to death but not resulting in the un Atherosclerotic Cardiovascular Disease	identying educe given in the direct	Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✓ Unknown			
Records, The law require ificate has been si r, page 2 should b	Completed		a	Was an autopsy prior to completion of cause of death? Yes 2 No 1 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 No 1 ✓ Yes 2 No			
tal Rection: The	Bec	25. Was case referred to medical examiner?	26.Place of Death (Check only one) 3 DOA Other A Nursing Home 5				
n of Vital	의	1 ✓ Yes 2 No Impatient 2 ✓ Ervourpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of In		ibe how injury occurred			
Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	Pending Accident Suicide Homicide Pending Investigation Could not be determined Specify) Pending Investigation See. Place of Injury - At home, farm, street (Specify)	t, factory, office building, etc. 28f. Locati	ion (Street and Number or Rural Route Number, City wn, State)			
To the Hospital within 24 hours To the Funeral completely filled	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurr (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation	ed at the time, date and place, and due to the on, in my opinion, death occurred at the time, or	cause(s) and manner as stated. date and place, and due to the cause(s)			
To To	ğ						
		hijai, ws	O.C.M.E.	November 2, 2009			
		Name and address of person who completed cause of death (Item 23a) Ling Li, MD	t, Baltimore, MD 21201				
St.	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 0

4a. Facility Name (if not institution, give street and number) 14 TURNMILL COURT Social Security Number 217-29-4000 Social Security Number 217-29-4000 Social Security Number 3 Social Security Number 4 Social Security Number 3 Social Security Number 4 Social Security Number 4 Social Security Number 5 Social Security Number 4 Social Security Number 5 Social Security Number 4 Social Security Number 5 Social Security Number 5 Social Security Number 5 Social Security Number 5 Social Security Number 5 Social Security Number 5 Social Security Number 5 Social Security Number 5 Social Security Number 5 Social Security Number 6 Sex 217-29-4000 10b. County 10c. City, Town or Location PERRY HALL 10c. Stype Social Security Number 9423 KILLBRIDE COURT 11. Marital Status 1 Social Security Number 9423 KILLBRIDE COURT 11. Marital Status 1 Social Security Number 12. Was Decedent Ever in U.S. Armed Forces? 1 Social Security Number 10c. City, Town or Location PERRY HALL 10de Stype Social Security Number 11. Marital Status 1 Social Security Number 12. Was Decedent Ever in U.S. Armed Forces? 1 Social Security Number 12. Was Decedent Ever in U.S. Armed Forces? 1 Social Security Number 10de Stype Social Security Number 11. Marital Status 1 Social Security Number 11. Marital Status 1 Social Security Number 12. Was Decedent Ever in U.S. Armed Forces? 1 Social Security Number 12. Was Decedent Ever in U.S. Armed Forces? 1 Social Security Number 1 Social Security Number 1 Social Security Number 1 Social Security Number 1 Social Security Number 1 Social Security Number 1 Social Security Number 1 Social Security Number 1 Social Security Number 1 Social Security Number 1 Social Security Number 1 Social Security Number 1 Social Security Number 1 Social Security Number 1 Social Security Number 1 Social Security Number 1 Social Security Number 1 Social Security Number 1 Social Security Humber 1 Social Security Humber 1 Social Security Humber 1 Social Security Humber 1	Year 2 009 9:40 AM
As a facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1 TURNMILL COURT 1 TURNMILL COURT 5. Social Security Number 6. Sex 41 Yrs. 1 Indeer 124 Hrs. 6. Date of Birth Months Days Hours Min. M	2009 4:40
The function of the first winds	ty of Death
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location 10d. State 11d. Marital Status 11d. Marita	BALTIMORE
The proof of the p	9. Birthplace (State or Foreign DOMINICAN REPUBLIC
JOSE AUGUSTIN TORRES OFIDIA MERCEDES 19a. Informant's Name/Relationship (Type. Print) KIRSON JIMINEZ/BROTHER 12143 SUGAR MILL CIRCLE, BALTIMO 20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 10 DONA ANTONIA 21. Signature of Funeral Service Licensee 22 Name and Address of Eacility 22 ETLER INC. FUNERAL	10d. Inside City Limits
JOSE AUGUSTIN TORRES OFIDIA MERCEDES 19a. Informant's Name/Relationship (Type. Print) KIRSON JIMINEZ/BROTHER 12143 SUGAR MILL CIRCLE, BALTIMO 20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 10 DONA ANTONIA 21. Signature of Funeral Service Licensee 22 Name and Address of Eacility 22 ETLER INC. FUNERAL	1 □Yes 2 🔀 No
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21. Signature of Funeral Service Licensee LTLLY & ZEILER INC. FUNERAL 1901 EASTERN AVENUE, BALTIMON	n-City or Town, State INTONIA CAN REPUBLIC
	HOME RE,MD 21231
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	Approximate Interval Between Onset and Death Smenths
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulstase or Irighry that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
23c. If yes, outcome of pregnancy 23d. Da 23b. Was decedent pregnant in the past 12 months? 1	ate of delivery nonth Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use conditions of the property of the	ntribute to the cause of death? 3 Probably 4 Unknown
1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No 24b. autopsy performed? 1 Yes 2 No	. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
The state of the s	
Tospital. 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 10 Others	
28d. Describe how injury occur Secondary Continuous	nber or Rural Route Number,
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier (29b. Date signed) 29c. License number (29d. Date signed)	manner as stated. e, and due to the cause(s)
29d. Date signe	ed (Month, Day, Year)
	·
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	iber 2,2009
State State 31. Date filed (Month, Day, Year) 32. Registrars Signature 34. Date filed (Month, Day, Year) 32. Registrars Signature 33. Registrars Signature	

Amend #7 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARVIN LEONARD VENICK NOVEMBER 2009 5:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** COURTLAND GARDENS BALTIMORE BALTIMORE 8. Date of Birth (Month, Day, Yea 11-29-1932 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1**X** M 2□ F Hours 216-28-9693 76 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, If a Modical Eventine Institute to authorite and once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2706-D JEREMY COURT 21209 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 (∄Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PHARMACIST PHARMACEUTICAL 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ALBERT VENICK BESSIE SACHS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOAN H. VENICK/WIFE 2706-D JEREMY COURT, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW 4 ☐ Donation 5 ☐ Other (Specify) 11-03-2009 | REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 21. Signature of Funeral Service Licens 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 7001HW1 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a consequence of) the Hospital or Attending Physiclan: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year Day 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☑ № 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 TV/NC 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manne of Death After t 28b. Time of 28d. Describe how injury occurred 1 / Natural s after dea. ral Director: Affr 5 ☐ Pending investigation 1 ☐ Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 30. Name and address of cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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	_		Millia	M)		D42	410		10/30/0	7
	2		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type,	Print) STA	705	Time	Willim.	ND21093
	Sta Registra		31. Date filed (Month, Day, Year) NOV 0 4 2009	32. Registrar's	s Signature			- 1/1/0	20101111	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 35441 1 - State Registrar 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death **Physician** Month Year i Charel 01:39 AM /Medical OCTOBER 2009 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAINT AGNES HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month Day. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 MM 2 □ F 35 213-86-2360 Yrs. lanc Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director timore 1 ¥6s 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3206 U. S Wood 21207 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired), 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 16/12 17. Father's Name (First Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ Kobertson 19a Informant's Name/Relationship (Type. Print)Core 19b. Mailing Address (Street and Number or Rural Soute Number, City or Town, State, Zip Code) Harracks 3206 1207 Cit. O. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ R 4 Donation 5 ☐ Other (Specify) 3 Removal from State -2009 Anne and Address of Fac Nam 1701 01 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA disease or condition resulting in death) DAYS Due to (or as a consequence of): CARDIOMYOPATHY DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Ye ar 5 ☐ Other (specify). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RETARDATION MENTAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed? 1 □Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 🗀 No 1 🗆 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 □ No 1 Nonpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Injury at Work? (Month, Day, Year) 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Examiner The law requires that the death certificate be executed MICHAE Box 68760 attending physician for use as the buria the O. σ. ģ signed t Division of Vital Records, s certificate has the Hospital or Attending Physician: director, filled in by the 24 hours after deat Funeral Director: completely within 2 To the I

Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Ire Magnote.

Physician

/Medical

filed within 72 hours after death with the Marylanc

Baltimore, Maryland 21215-0036

State

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) NOV - 4 2009

Registrar DHMH 17 Rev 1/2001 900

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KALISETTI,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

P22002

CATON AVENUE, BALTIMORE, MD-21229

29d. Date signed (Month, Day, Year)

OCTOBER, 30th, 2009

ILENE ZORN

		Ple 1 _ For State	ase Type or Pr State of M	laryland / Depa	artment of l	Health and I	All Copie Mental Hy	es Are I	Legible. 2 N N 9	35442
Physicia		Registrar 1. Decedent's Name (First, Midd. Ilene S. Zorr.	le, Last)	Cer	tificate of	Death	2. Date of Domestry Month	Reg. No.	Year	3. Time of Death
Medic Examin		4a. Facility Name (if not institution Stella Maris	n, give street and number)		4b. City, Town, c	or Location of Death		4c. C	2009 County of Death	
Funeral Director		5. Social Security Number 218–26–9474 Usual Residence of Decedent		ge (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days		71928	9. Birth	place (State or Foreign	
Maryland 28a-f show otified at	irector	10a. State 10b. County MD Harf		10c. City, Town or Loc Bel Air	cation					10d. Inside City Limits 1 ☐ Yes 2 【 No
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Bal permi Depar Impo any in		23a. Part 1. Enter the disease, or shock, or heart failure. List	Complications that caused	/ 11	750 Bela	ir Road -	- Kings	ville,		Home, P.A. and 21087
Servificate be executed was miner and inding physician and see as the burial-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or impury that initiated events resulting in death) Last	b. Due to (or as a Due to (or a) Due to	a consequence of): a consequence of):	IA					Onset and Death
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Div e Hospital or n 24 hours afte e Funeral Dir	Medical ((Check 2 ☐ Medical E	Physician: To the best of examiner: On the basis of examiner: To the l	amination and/or investig	ation, in my opinio	 n. death occurred at 	d due to the car	use(s) and m	d due to the car	se(s) and manner stated
To the within 2 To the comple		29b. Signature and ittle of contifier	SUNP		29c. License				igned (Month, I	
		30. Name and address of person of JACKIE JONES,	CRNP 2300 I	ULANEY VAL		TIMONIUM	, MD 21	.093		
State Registra	ŕ	NOV 04	2009 32 Aegistra	r's Signature	Had					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MONTH VIBER Day Helena Noberta Zlomke 04:20AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Balt Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth g. Birthplace (State or Foreign 1 □ M 2 🔀 F Month Day, Ye Country Months Days Hours Min. **Director** 214.14.1289 88 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral filed within 72 hours after death with 21224 U.S.A. 422 Elrino Street 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Yes 2-No Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72... th and Mental Hygiene. ?7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sophia unknown John Wisniewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Lee Zlomke/Husband Elrino St., 422 Balto., MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 11.03.09 Beltsville, 4 Donation 5 Other (Specify) Chesapeake Crem. 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, PA 21. Signature of Funeral Service Licensee 8717 Green Pastures Dr. Balto., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner URINARY TRACT INFECTION Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Dividitor as a consequence of sician and burial-transit resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by be det 23e. Did tobacco use contribute to the cause of death? þ PEROSMOLAR Division of Vital Records, 1 🗌 Yes 2 No Completed 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate Yes 2 No 1 Ves 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 X No 1 Inpatient 2 🗆 ပ ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certification 29c. License number 29d, Date signed (Month, Day, Year) 3 O D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOON FOH LIM. 7601 OSLER DRIVE TOWSON. MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV - 4 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 19, BONNIE Κ. BURGER OCT. 2009 7:34 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🛛 F Months Days Hours Director 372**-**60-5176 55 MICHÍGAN 15,1954 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mast be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐Yes 2 ☐ No PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2206 CALVERT ST. Completed by Funeral 20783 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CHEMICAL ENGINEER **EXXON** 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) BYRON 2 BURGER LUELLA BARNS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GORDON BAUM/HUSBAND 2206 CALVERT ST., HYATTSVILLE, MD. 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHAMBERS CREMATORY 10-22-2009 RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility AL HOME & CREMATORIUM, P.A. Chambus 5801 CLEVELAND AVE., RIVERDALE, MD. M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Card /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any trading to it. I detect cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 MNo Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to peath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? s certificate has tirector, page 2 s 24a. Was an autopsy perform Cancer 2 No 2 No 1 ☐Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 30. Name and address person who completed cause of death (Item 23a) (Type, Print) PING LI, M.D. 3001 HOSPITAL DR., CHEVERLY, MD. 20785 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

OCT

22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year rown oan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard Howard County General Hospital Columbia er 1 Year | If Unde 5. Social Security Number If Unde 8. Date of Birth (Month, Day, Year) 6/26/1934 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 M 2 4 Hours Months Davs Min. Director 070-28-7076 NY Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location show 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD Howard Ellicott City 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 Funeral 9621 Longview Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □Yes 2X No If Yes, Give Year or Dates: þ Specify 3 ₩ Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Secretary Columbia Gas or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Pages 1 and 2 should be ပ Albert Hang Department of Health and Me Important: If item 27 is mark any injury or other traumationce. Margaret Hartman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Brown - daughter 317 W. 21st Street Apt. 3A New York, NY 10011 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Cremation Serv 10/21/2009 | Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 21. Signat of Aneral erv e Licensee M01411 4112 Old Columbia Pike Ellicott City, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** vocardia ntaction disease or condition resulting in death) /Medical Due to fras a consequence of): **Examiner** ttherosclerot Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) P.0. the 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an has page 2 autopsy performed certificate 1 □Yes 2 **N**o Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1☑Yes 2□No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. n 24 hours after death.

ne Funeral Director: Apletely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical npletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) n 1 0002771 0/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Barks

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Begistrar's Signature

ane

Columbia, MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Oct Mable Υ. Bailev 15 12:18 A M 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Month, Day, Feb 23 Florida 253 56 5803 72 Yrs. 1937 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's Maryland 1 Yes 2 v No Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8722 Cumbria Court 20744 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Yes 2 XXIII 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X YNo Specify Specify: Black 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Para Professional Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest McPherson, Sr. Corine Moblev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaVisa Bentley (Daughter) 8115 Knightsbridge Street, White Plains, MD 20695 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory October 20,2009 Clinton, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Ons and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consumence of): resulting in death) Last 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician/ Medical Examiner

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To the Funeral Director: At completed filled in by the fu

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Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760

P.O.

Division of Vital Records,

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10a. State

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al Hygiene. I other than "

permit. Page 1 and 2 should be filed. Department of Health and Mental H-Important If item 27 is more any injury or other.

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Maryland 21215-0036

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Funeral

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Certificate:

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 X No 9 Unknown

25. Was case referred to medica

2 No

5 Pending

Investigation

determined

6 Could not be

examiner?

1 🗀 Yes

27. Mann Death

Natural

Accident

Suicide

4 Homicide

29a, Certifier

(Check only one 29b. Signature and t 1 Yes 2 No 3 Probably 4 deliknown

24a. Was an autopsy performed? Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes

26. Place of Death (Check only one) Other: ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at 28d. Describe how injury occurred work?
1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Vertifying Physician. On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nyrse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

pleted cause of death (Item 23a) (Type, Print

Hospital

1 Inpatient 2

28a. Date of injury (Month, Day, Year)

31. Date filed (Month, Day,

Registrar's Signature

28b. Time of

DHMH 17 Rev 7/2009

State Registrar

09-0789	97		
Paul V	Brown	111	

State of Maryland / Department of Health and Mental Hygiene 2009 35447 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day October 11, 2009 0655 hrs Medical Examiner PAUL V. BROWN III c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Clinton Southern Hospital 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** oreignSilver Months Days Hours Min Director Count 1X M Yrs pring, MD 2 F /7/1986 216-23-4042 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ì 1 X Yes 2 No 28a-f show 23a or 28a-f shoven notified at once. Maryland Prince George's Upper Marlboro Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20772 United States 13400 Croom Road 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status narked other than "natural", or items event, the Medical Examiner must be White, etc. Armed Forces? 1 X Never Married 2 utimore, MD 21215-0036

it. Pages I and 2 should be filed within 72 hours after dea ritment of Health and Mental Hygiene.

rrant: If item 27 is marked other than "natural" not other traumational." 2 X No Yes Specify: Black 2X No specify: If Yes, Give Year Widowed Divorced Yes β 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Non Applicable Unemployed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carmasietta Sindor Bean Paul Vincent Brown Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3400 Croom Road Upper Marlboro, Maryland 20772 of Disposition (Name of cemetery, Date 20c. Location - City or Town, State <u> Paul Vincent Brown Jr,/ Father</u> 20b. Place of Disposition (Name of cemetery, Baltimore, Permit. Pages 1 and 20a. Method of Disposition crematory or other place) Burial 2 XXCremation 3 Removal from State Department of Important: I 10/20/2009 Riverdale, Maryland Donation 5 Other Specify? Riverdale Crematory 22. Name and Address of Facility ope Funeral Homes, P.A. 21. Signature of Funeral Service Livensee Marlboro Pike Forestville, Maryland 20747 Pat I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death Medical Gunshot Wound of Head Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical physician the burial -UNPENDED **AMENDED** The law requires that the death certificate be Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy IE EEMALE: 3 Ectopic pregnancy Year 23b. Was decedent pregnant in the Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown è Completed 24b. Were autopsy findings available as been s 2 should b 24a. Was an prior to completion of cause of autopsy death? has performed? Nο After this certificate h funeral director, page Yes 2 1 🗸 Yes 26 Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 Other; Other Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Subject shot Certification: FOUND: Natural n 24 hours after death.

re Funeral Director: A letely filled in by the fu 1. Yes 2 ✔ No Pending Oct 11, 2009 0556 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 or Town, State) 3004 Tracy Lane, Forestville, MD Suicide determined (Specify) Townhouse / Rowhouse 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 12, 2009 O.C.M.E. - im 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD State Date filed (Month Registrar

DHMH 17 Rev 1/2001 OCM=2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Hubert Year Ray Brown /Medical 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death TONINS 4LA KIGIONAL MODICAL SOLISBURG NICOMICO 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Days Hours Min 220-28-0046 1 M 2 □ F 81 Director 08/13/1928 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryla I Hygiene. other than "netural", or items 23a or 28a-1 shoventhe and the man and the man end, it is a feet of the and the man and the ma Maryland Wicomico Salisbury 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4599 Coulbourne Mill Road 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Army Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: <u>6</u> Specify: white 3 Widowed 4 ☐ Divorced Army Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) carpenter construction armit. Pages 1 and 2 should be filed wapartment of Health and Mental Hygie portant: If item 27 Is marked other to yinfury or other traumatic event, In. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raleight Day Brown Grace Farlow ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 29591 Mill Stream Dr., Salisbury, MD 21804 19a. Informant's Name/Relationship (Type. Print)
Susan Megargee/daughter 20b. Place of Disposition (Name of Wicomico Memorial) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any inlury or ot Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/21/09 Salisbury, MD Park Tal Survice Licenses 22 Holloways Fundral Home Professional Association 501 Snow Hill Rd., Salisbury MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrevascular Accident /Medical Due to (or as a consequence of): Examiner Hemolytea Anemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician an s the burial-tr Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed 1 □Yes 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director. the l in by 1 filled completely

The law requires that the death certificate be executed

Box 68760,

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page 2

with the Maryland

Baltimore, Maryland 21215-0036

Is marked other

Medical

DHMH 17 Rev 1/2001

State

29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day,

and manner stated.

32 Registrar's Signatu

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D68222

DIVISION ST. SUITE B

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Year Elizabeth Phillips Brown October 16 2009 /Medical 6:30 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Nursing Home Salisbury Wicomico Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 213-14-6375 1 □ M 2 € F 87 Director Maryland 07/21/1922 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at show 1 XYes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 'must be n 900 Booth Street 21801 USA Funeral death ortant: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2**X** No þ Specify Specify: 3 Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) housewife domestic Department of Health and Mental Hygie Important: If item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Clarence Phillips Mary Ellen McIntyre ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1705 Somers Dr., Salisbury, MD 21804 Robert F. Brown Sr/son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bethel U.M. Church 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/23/09 Cemetery Walston Switch, MD 22. Same and Address of Facility Holloway Funeral Home Professional Association 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter of identitying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical as the the attending IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No certificate has autonsy perform 1∐ Yes 20 No Physician: 25. Was case referre o medical examiner? Be 26. Place of Death (Check only one, Other: 1 ☐ Yes 2 No မ 1 ☐ inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Many r of Death 28a. Date of Injury 28b. Time of I or Attending Patter death.

Director: After 1 After 1 Certification; 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide thin 24 hours a Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahesha Thimmarayappa M.D. 614 Easternshore Dr Salisbury MD 21804 31. Date filed (Month, Day, 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2009

			For State Registrar	ate of Marylan		irtment o <i>tificate d</i>			-	giene Reg. No.	200	9	35450
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of De Month	Day	/ Year		Time of Death
	/Medic	cal	CHARITY 4a. Facility Name (If not institution, give stree	t and number)	CA.	LLAN 4b. City, Towr	or Locatio	on of Death	OCTOBE		2009 County of Dea		:45A M
	Examir Funeral Director	ner	FREDERICK MEMORIAL 5. Social Security Number 077-42-1012	HOSPITAL 7. Age (In yrs. I		FREDE If Under 1 Ye Months Da	RICK ar If Unc	der 24 Hrs.	8. Date of Bir (Month, Da Nov. 10	th	FREDERI 9. Bir	CK	(State or Foreign
70			Usual Residence of Decedent 10a, State 10b, County	100 Cib	, Town or Lo	ation .							side City Limits
Maryla	f sho	P	Maryland Frederick		ederic							1	□Yes 2□No
h the I	r 28a-	Directo	10e. Street and Number	FI	edelic	10f. Zip Cod	le			10g. Citi	zen of What Co		Λ
th wit	23a o	ralD	504 West Second Str	eet		21701					U.S.A.		
72 hours after death with the Maryland	l", or items	by Funeral	1 Never Married 2 Married 1	Vas Decedent Ever in U.9 rmed Forces? ☐Yes 2 M No Yes, Give ear or Dates:		Vas Decedent of Yes, specify C			ecify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whit		
ithin 72 hours af	and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade con	n npleted) college (1-4or 5+)	(Give life. L	dent's Usual Oc kind of work do DO NOT use rel	ne during m tired)				nd of Business	/Industry	-
led wi	Hygier ther th	S	17. Father's Name (First, Middle, Last)	6	Histo	ric Pre			st e (First, Middle,		ate of	Mary	land
Marylaric d 2 should be file	d Mental I narked of natic ever	To Be	Paul Vanderbilt		40) 14 77		Ma	rian 1	Lambert		,	7: 0 /	
<u> </u>			19a. Informant's Name/Relationship (Type. F G. Bernard Callan /		1	-			al Route Numbe , Frede				9)
S +			20a. Method of Disposition	20b. P	lace of Dispo emetery, cren	sition (Name of natory or other	place)		Date	20c. Lo	cation - City or	Town, S	State
. Pages	tment o tant; If i jury or		1 ☐ Burial 2 X Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	val from State 1	thsbur	g Crema	tory				hsburg,		
permit	Department of important; if any injury or once.		21. Signature of Funeral Service Licensee	fr.	12	<u>01 NORT</u>	H MAR	KET ST	SON FUN	FRED	HOMES,	P.A MD 2	A. 21701
. /	ysician Medical aminer		23a. Part 1. Enter the disease, or complicated shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	_ardopul_v Due to (or as a consequ	nonos	Arro		as cardiac (or respiratory a	rrest,		Inter	roximate val Between et and Death
ficate be executed	an and riat-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	Hydro	nebyro.	515					_	
ficate be	physici the bu	edical	d	Cervicel C	ance 2	-							
law requires that the death certifi	been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	yes, outcome of pregna □ Live birth 2□ Fetal □ Pregnant at time of d □ Unknown	death 3	Ectopic pregn Other (specify				2	23d. Date of de Month	livery Day	Year
quires that	n signed by	δ	Part II. Other significant conditions contribute	ting to death but not resu	Ilting in the ur	derlying cause	given in Pa	art I.			se contribute t		use of death?
ician; The law requires t	ate has bee page 2 sho	Completed							24a. Was autor perfo 1 □Yes		prior to	utopsy fi complet	ndings available ion of cause of No
ilcian	certific ector,	æ	25. Was case referred to medical examiner? 1	al.			Othor:		Check only o	ne)			
ding Phys	n. After this funeral di	tion: To	I les zigno	Ba. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. li	njury at Vork?		me 5 Resident			ecify)	
al or Attending	within 24 buous arter doeath. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2 s.	Certification: To	a Deviside 6 Could not be	le. Place of Injury - At ho building, etc. (Specify	me, farm, stre				28f. Location (S City or Tou	Street an vn, State,	d Number or R	ural Rou	te Number,
te Hospit	n 24 hours te Funera bletely fille	Medical C	29a. Certifier (Check only one) 1 ✓ Certifying Physicial 2 ☐ Medical Examiner:	n: To the best of my known the basis of examination manner stated.	wiedge, death tion and/or in	occurred at the	e time, date ny opinion,	e and place, death occur	and due to the red at the time,	cause(s) date and) and manner a I place, and du	s stated e to the o	cause(s)
		ž	29b. Signature and title of certifier			-	ense numbe				e signed (Mon		Year)
	DAD		Shoal Di				068	977		10.	-19-09	1	
	V		30. Name and address of person who comple Shoaib Ali, MD 400	ted cause of death (Item West 7th St			ick, N	MD 217	01				
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2.0 2009	32. Registrar's Signat	ture.	arkel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ October 2009 6:10 William F. Clark Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gwynn Oak 1727 A Champlain Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours XXM 2 ☐ F 39379947 Marvland Director 62 217-46-4111 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Director 1 Yes 2 No Gwynn Oak Baltimore Md10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ò permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertal Hyglene. Important: If the Zf is marked other than "natural", or items 23a or important: If them Zf is marked other than "natural", or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be. Funeral 21207 USA 1727 A Champlain Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 Xyes 2 No. 1965- Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc Completed by 1 Never Married 2 Married Specify: White 1 Yes X No 3 Widowed 4 X Divorced 1971 Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Law Enforcement Police Officer 12vrs Be Page 1 and 2 should be filed vent of Health and Mental Hygant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Doris E. Arnold Leroy W. Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1540 Ingleside Ave. Baltimore, Md. 21207 Johnette Reid/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🕏 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory Inc. 10/21/2009 Hanover, Md. 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. Signature of Funeral Service License 4112 Old Columbia Pike Ellicott City, Md. 21043 MOO845 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pharyngeal Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Dav Veal Pregnant at time of death been signed by the sand should be detached g 🗌 Unknown 9 Unknown Hospital or Attending Physician: The law requires that 1 24 hours after death. Funeral Director: After this certificate has been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 X Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I; page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? **Division of Vital** funeral director. Be 26. Place of Death (Check only one) ၉ 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work' 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check

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within 2 To the I

3

only one)

29b. Signature and title of of

31. Date filed (Mon 0C1

30. Name and address of person

Andleeb Khan M.D.

21 2009

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

DHMH 17 Rev 7/2009

State

Registrar

Barks

completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

CLEAN

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

79357

16 South Eutaw Street Suite 400 Baltimore, Md. 21201

29d. Date signed (Month, Day, Year)

10/21/2009

DHMH 17 Rev 1/2001

Registrar

OCT 212009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year BATEMAN, CHAMBERS 1:20 AM 2009 /Medical 10 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death VA MEDICAL CENTER BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 12/21/1936 **Funeral** Months 1 ☑ M 2 □ F Days Hours Min. 72 Director 253-48-5605 Georgia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Ilmportant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, II woulded Examiner must be seen any Injury or other traumatic event, II woulded Examiner must be seen 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 515 Harbor Drive 21403 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 MYes 2 □ No If Yes, Give Year or Dates:1955-61 Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 ☑ No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Automobile Mechanic Automobile Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William R. Chambers Alice M. Cherry ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn C. Chambers/ Wife 515 Harbor Drive, Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 10/20/09 Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) Edgewater, MD 21. Signatur of Funeral Service Ligensee 22. Name and Address of Facility George P. Kalas Funeral Home Moto 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ST ELEVATION MY OCARISIAL INFARCTION MON resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of Physician: The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of) Box 68760, attending phi for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

54 W

Registrar

31. Date filed (Month, Day, Year)

MICHAN

29b. Signature and title of certifier

MD 10

and manner stated.

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 2 0 2009

ELTAKI

32. Registrar's Signature

NORTH

1104088772

29d. Date signed (Month, Day, Year)

GREENE STREET RALTIMORE MIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35454 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Arthur C. Cleaves 2009 October 3:45 P^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Asbury Solomons Island Solomons Calvert Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) King George, VA 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Days Hours 1 🔀 M 2 🗆 (Month, Day, Year) 8/31/1926 Director 231-20-1923 83 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🏝 Yes 2 🗌 No MD Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11450 Asbury Circle Apt. 408 USA 20688 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Completed 3 Divorced 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Master 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Building Engineer/Electrician Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Benjamin Franklin Cleaves Etta B. Cooke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Barbara S. Cleaves/Wife</u> 11450 Asbury Circle Apt. 408 Solomons, MD 20688 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 10/22/2009 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Klonga Montgomeny 3401 Bladensburg Road Brentwood, Maryland 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician, GESTILE EMENTID disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Ye URI Sequentially rist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after clearh.

To the Funeral Director: After this certificate has been signed by the attending house made. the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? for Pregnant at time of death Month Year Dav 2 No s been signed by the should be detached 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABUTUS 1 \square Yes 2 \blacksquare No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 perform 1 Yes 2 No 1 ☐ Yes 2 🛣 No s after death.

I Director: After this certific d in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🔀 No 1 🗆 Yes Other: 은 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2,0 d address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year, OCT 2 2 2009

mo

			1 - State State of Maryland / De	dartment of Health and N ertificate of Death		ene . No. 2009	35455
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Phyllis Lydia Culler		2. Date of Death	30, 2009 ^{ar}	3. Time of Death 5:00 AM
100	Examir		4a. Facility Name (If not institution, give street and number) 5639 A Jefferson Pike	4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
	Funeral Director		5 Sozial Sayurity Number 6. Sex 7. Age (In yrs. last birthda 1 □ M 2X F 83 Yrs.		8. Date of Birth (Month, Day, Ye	ear) 9. Birth	nplace (State or Foreign intry)
	show	ō	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Maryland Frederick Freder:				10d. Inside City Limits 1 ☐ Yes 2 No
	with the Na or 28a-1	I Director	10e. Street and Number 5639 A Jefferson Pike	10f. Zip Code 21703		. Citizen of What Cou	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydroal Event must be notified at once.	by Funeral		3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - Amer Black, White Specify: Wh	etc.
Baltimore, Maryland 21215-0036	within 72 hou glene. r than "natura the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) (Gingle Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation we kind of work done during most of work by DO NOT use retired) conemaker	ing 161	b. Kind of Business/li Own Hom	
and	ld be filed ental Hyg ked other ic event,	To Be C	17. Father's Name (First, Middle, Last) Osceola Gordon	18. Mother's Nam	e (First, Middle, Mai	iden Surname)	
Mary	nd 2 shou alth and M 27 is mar r traumat		19a. Informant's Name/Relationship (Type. Print) 19b. Ma	illing Address (Street and Number or Rui 3 Jefferson Pike, F	ral Route Number, C	ity or Town, State, Z	,,
imore,	Pages 1 a nent of He ant: If item ıry or othe	1 3	20a. Method of Disposition 20b. Place of Dis		Date 200	c. Location - City or T	own, State
Balt	permit. Departi Importi any Inji	j j	21. Signature of Peneral Service Lichnsee MO0255	22 Name and Address of Eacility Keeney and Basford 106 East Church S	d PA Funei	ral Home rick. MD 2	21701
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (*as a consequence of):	inter the mode of dying, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
	/Medical Examiner	L	resulting in death) Due to (*\text{as a consequence of}): Sequentially list conditions, b.	le my=lo	~77		547
Ď,	ificate be executed physician and ts the burial-transit	Examiner	Sequentially list conditions, library and the sequential control of th				
		Medical	d	_			
)	the death certifi y the attending iched for use as	Physician/M		E Ctopic pregnancy Other (specify)		23d. Date of deline Month	very Day Year
rds, P.	w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to	the cause of death?
Yec	The lar ate has page 2	Completed			24a. Was an autopsy performed	prior to code death?	opsy findings available ompletion of cause of
	Physician; The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Othori	h (Check only one)	e 6 □Other (Spec	<i>i</i> . A. A.
Ion of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Accident State of Injury (Month, Day, Year) 28a. Date of Injury (Month, Day, Year) (Month, Day, Year) 1 Natural State of Injury (Month, Day, Year) 1 Natural State of Injury (Month, Day, Year)	of 28c. Injury at	28d. Describe how i		ny)
DIVISION	tal or Atters after de al Directo ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rui tate)	al Route Number,
	he Hospii in 24 hour he Funera pletely fill	Medical	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the caus red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
)	Verith Com	Σ	29b. Signature and title of certifier	29c. License number 0146 26	. 0.	Date signed (Month)	
7			30. Name and address of person who completed cause of death (Item 23a) (Type	Drint\	_	-105 m	0 2170/
	Stat Registra	~	31. Date filed (Month, Day, Year) 32. Registrar's Signature	bake			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day William Randolph Dorsey October 9, 2009 2215 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. 8, Date of Birth (Month, Day, Dec. 3, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 107-22-5790 Pittsburgh, PA 77 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1009 Cresthaven Drive 20903 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Date \$ 955 – 1957 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No **Black** Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Agent Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George William Dorsey Elizabeth Randolph 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie Evette Dorsey Caster 12715 Woodbridge Court, Mitchellville, MD 20721 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 10/20/2009 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McGuire Funeral Service, 7400 Georgia Avenue, NW Wash., DC 20012 tanna 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bilateral Pneumonia Weeks Due to (or as a consequence of):
Respiratory Failure Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or es a consequence of) Due to (or as a consequence of): yes, outcome of pregnancy □ Live birth 2 □ Fetal death □ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Ye ar Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Lung Cancer, Dementia 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖟 No 1 poatient 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It of Medical Examinations to neithed at

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

Hospital or Attending Physician: The law requires that the death certificate be executed thous after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the buria-transit

Examine

Physician/Medical

þ

Completed

Be

Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

27. Manner of Death

1 Natural 2 ☐ Accident

3 Suicide

29a, Certifier

4 Homicide

Date of Injury (Month, Day, Year) 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

5 Pending

investigation 6 Could not be determined

> 29c. License number D0065485

29d. Date signed (Month, Day, Year) 10/10/200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Supanich PSM MD

Barbara Supanich RSM, MD Holy Cross Hospital, 1500 Forest Glen Road, Silver Spring,

State Registrar 31. Date filed (Month, Day, Year)



within 24 hours aft

To the Funeral Di

completely filled in

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Physician /Medical Examiner Examine

Physician

/Medical

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10a, State

Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatte event, the Medical Evander in ust by notified at any Injury or other traumatte event, the Medical Evander in ust by notified at any Injury or other traumatte.

Baltimore, Maryland 21215-0036

physician and s the burial-trans for use as signed by the a cate has b this certificate To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

Physician/Medical

Completed by

Be

Certification:

Medical

29a, Certifier

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

Third-Degree Heart Block with Hypothy-vidism

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 🗌 Yes

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 [2] Natural 5 Pending investigation 2 Accident

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 28c. Injury at Work? 1 □Yes 2 □ No

28d. Describe how injury occurred

6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

and manner stated

28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and otle of

29c, License number D 31001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) October 19, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7500 Greenway Center Drive,#430 Greenbelt, Maryland 20770 Stuart Turkewitz, M.D.

State Registrar 31. Date filed (Month, Day, Year) OCT 22 2009



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	N.		1 - State Registrar		,	Certificate of I	Death		Reg. No.	
	Physicia Medic			Irwin DIE	rerich			2. Date of Dea Month	th ZUU	3. 10:10AM
	Examir	er	4a. Facility Name (if not institution, give Washington Coun	ty Hospita		Hager			4c. County of Dea Washing	
	Funeral Director			ex 7. Age	(In yrs. last birth	Mantha Dava	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, May 5,	9. Bi	rthplace (State or Foreign Puntry) aryland
	Maryland 28a-f show notified at	Funeral Director	Usual Residence of Decedent 10a. State Maryland Washing		10c. City, Town Hager	stown				10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	h with the ns 23a or nust be	neral [10e. Street and Number 2250 Beverly Dri	ve		10f. Zip Code	21740		10g. Citizen of What C	ountry?
9003	is filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 ☐ Never Married 2 🖾 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 1 1 1 Yes 2 1 N If Yes, Give Year or Dates.	er in U.S. to 1943 1946	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🕱 No		cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: whi	te, etc.
215-	iin 72 hoi e. han "nat e Medica	Completed	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12))	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired)	ation during most of working	ng	16b. Kind of Business	
Baltimore, Maryland 21215-0036		(A)	17. Father's Name (First, Middle, Last)	Vinson Die		lectrician	18. Mother's Name			vernment
laryla	should be fi and Mental is marked aumatic ev	-	19a. Informant's Name/Relationship (7	iype, Print)	19b.	Mailing Address (Street	and Number or Rura	. Pearl	City or Town, State, Z	ip Code)
re, M	permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		W. Kyd Dieterich 20a. Method of Disposition		20b. Place of	9932 Beaver Disposition (Name of	Creek Roa	ad, Hage	erstown, Ma	ryland 21740
ltimo		1 (4	1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Licenses)	fy)		crematory or other place town Cremat			20c. Location - City of Hagerstown	
Ba	Dep Imp any	1	Vrolet QU	2.l-		415 East W	ilson Blv	d., Hage		e aryland 21740
	hysician/ Medical	100	23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	plications that caused to the cause on each line. a. Due to (or as a cause)	he death. Do no	t enter the mode of dyin	g, such as cardiac oi	r respiratory arre	st,	Approximate Interval Between Onset and Death
	Examiner	ıer	Sequentially list conditions,	b. Tuab	1 / Ly	to eat				
	ecuted and I-transit	Examir	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Fro los	a ble	recurre Ferendia	uce h	un e	aucer	
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P.O. Box 68		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death	3 Ectopic pregnanc	у		23d. Date of de Month	livery Day Year
ds, P.O	quires that the services that the services by the details and be detailed.		Part II. Other significant conditions of Prevote IIa Recurrent	ontributing to death but DUCCAL	not resulting in	the underlying cause giv	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
Division of Vital Records,	sician: The law rec certificate has ber irector, page 2 sho	Completed by		meum	mas			24a. Was ar autops perform 1 Yes 2	y prior to death?	topsy findings available completion of cause of
Vital	ysician s certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	t 2 🗆 EB/Outs	26. Pla	er:			
on of	anding Ph sath. nr. After thi	Certificate: 1	27. Manner of Death Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, 1	28b. Tir	me of 28c. Injury ury work	at 2		nce 6 Other (Spec w injury occurred	erry)
Divisi	al or Atters as after de al Directo		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (n, street, factory, office	2	8f. Location (Str City or Town,	reet and Number or Ru , State)	ral Route Number,
	the Hospit in 24 hour the Funera	Medical	(Check 2 \square Medical Exami	ner : On the basis of exa	mination and/or	eath occured at the time, investigation, in my opinio dge, death occurred at the	 n death occurred at t 	he time date and	and due to the	cause(s) and manner stated
	North		29b. Signature and title of certifier May E: May	my w.		29c. License		29	9d. Date signed (Mont)	n, Day, Year)
j.	1-6+1		Nay E: Was 30. Name and address of person, who c Mary E: Won	ompleted cause of dea	th (Item 23a) (Ty 354 M	De Print) St. 1	Yagers	town.	WD 2,	740-
	Stat Registra	e r	31. Date filed (Month, Day, Year) OCT 26 2	32. Registrar's	Signature	back				

Durban, Austin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			T _ State	state of Marylan				l Mental Hy	giene		
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of L	Death		Reg. No. 2	09 35459	
Physicia Medic Examin		cal	Austin Gr				2. Date of De Month	T 23 2009 1105 da			
	Examir		Washington County F			4b. City, Town, o Hager		ath	4c. County of Wash:	^{f Death} ington	
	Funeral Director		== == =================================	7. Age (In yrs. le	ast birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		h (6,1934	9. Birthplace (State or Foreign Country) Maryland	
pu	ind ihow at		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limits	
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h with the	is 23a or nust be n	Funeral Director	10e. Street and Number 1528 Crest View Ave	nue		10f. Zip Code 217	40		10g. Citizen of Wh	-	
21215-0036 within 72 hours after death	nt of Health and Mental Hygiene. t. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Fur	1 Never Married 2 X Married	Was Decedent Ever in U.S Armed Forces? I ☑ Yes 2 ☐ No f Yes, Give ⁄ear or Dates.	"	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 🖾 No	ın, Mexican, Puei	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc. white	
15-(72 hou	ה" ה ledica	plet	15. Decedent's Educati (Specify only highest grade co		(Give k	ent's Usual Occup ind of work done o	ation during most of we	orking	16b. Kind of Busi	iness Industry	
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Midry 12 should alth and M 27 is mar	alth and N 127 is ma er trauma		19a. Informant's Name/Relationship (Type, P. Frances L. Durbin -						; City or Town, Stat	te, Zip Code) aryland 21740	
Baltimore, permit. Page 1 and	nent of He nt: If item ry or othe		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Remode 4 ☐ Donation 5 ☐ Other (Specify)	oval from State Ced	and of Discussion	ition (Name of atory or other place n Memori Par	-	Date ober 27, 2009	20c. Location - C		
Balti	Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee	stol	22.	Name and Address	s of Facility	Minnich	Funeral		
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau	ons that caused the death						Approximate	
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ficate t			d								
To the Hospital or Attending Physician: The law requires that the death certifuln 24 hours after death.	the attending p	Physician/N	in the past 12 months?	yes, outcome of pregnan Live Birth 2 Fetal Pregnant at time of de Unknown	death 3 🔲	Ectopic pregnancy Other (specify)	/		23d. Date of Month		
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law rec	as be	Completed				-500		24a. Was a		re autopsy findings available or to completion of cause of	
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P P P	ofter th		27. Manner of Death 28 1 ☑ Natural 5 ☑ Pending		28b. Time of injury	28c. Injury work?	at	28d. Describe ho	ence 6 Other (S w injury occurred	Specify)	
Attend	ctor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	e. Place of Injury - At hom	e form stree	M 1□Y	∕es 2 □ No				
pital or A	To the Funeral Director: After this certific completed filled in by the funeral director,	sal Cer	dotominos	building, etc. (Specify)				City or Town	, State)	r Rural Route Number,	
he Hos in 24 ho	he Fun	Medical	29a. Certiffer (Check 2 W Medical Examiner: Or only one) 3 Certifying Nurse Practical Control of the Control of	i the basis of examination a	and/or investig	ation in my oninior	death accurred	at the time date and	d place and due to	Also course (a) and accompany that all	
Jo t	To t		29b. Signature and title of certifier	.//		29c. License		2	9d. Date signed (M	onth, Day, Year)	
		-	30. Name and address of person who complete	ed cause of death (Item 2	(N)	nt) 90-	100+		oct 23	3,2009 wa,00	
HI	10-1	- 1	19 13/1 Orchan 1 to	maso Red	Sol	w. Ow E	Fitte m	0 1	lasers to	42)	
	State Registra	e	31. Date filed (Month De) Te 2 6 2009	32. Fegistrar's Signatur	6 1						

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Division of Vital Records, P.O. Box 68760,

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a ~ ^ ^ ^ _ any Injury or other traumatic event.

/Medical

10a. State

Funeral Director

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Completed

Be

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Medical

29a. Certifier

29b. Signature

(Check only one)

PAUL SNOW 31. Date filed (Month, Day, Year)

s been signe should be c

After this certificate has funeral director, page 2:

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

	sharck, or he art failure. List oprly o	ne cause on each line.		Onset and Death			
İ	immediate Cau e (Final disease or con lit on	ACCIDENTAL FALL	3 DAYS				
dical Examiner	resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	E	3 DAYS			
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnancy 1 Etve birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)					
		Intributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute 1 □ Yes 2 700 3 □	to the cause of death? Probably 4 Unknow			
Completed by		HY, CHROMIC KIDNEY DISEASE	- autopsy prior t	autopsy findings availab o completion of cause of ? es 2 □ No			
Be	25. Was case referred to medical examiner?	26. Place of De					
္	1 Yes 2 □ No		Home 5 ☐ Residence 6 ☐ Other (S	pecify)			
tion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 10-24-09 28b. Time of 28c. Injury at Work? 1 □ Yes 2 XNo	28d. Describe how injury occurred				
ertification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or City or Town, State) SHORED HEART / B				

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

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DIL

State Registrar and manner stated.

74 WEST

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m.D.

	1	For State Registrar				Ce	ertificate d	of De	ath		Reg. No.	200	9	35	46
ician		1. Decedent's Name (Fir								2. Date of De Month OCTOBE		200	3	3. Time of : 54	Death P M
dical			ARSHAI		umborl		4h City Town	n or loc	ation of Death			County of D		:)4	- FM
niner		free FREDERICK			OSPIT	'AL	FRED:					FREDE			
al or	- 1	5. Social Security Number 182–32–2518		.Sex 1⊠XM 2□ F	7. Age (I	n yrs. last birthda Yrs.	y) If Under 1 Ye Months Da		Under 24 Hrs. lours Min.	8. Date of Bi (Month, D 8/10/	rth ay, <i>Year)</i> 1942		Country)	e (State d) lvan:	_
	-	Usual Residence of Dece 10a. State 10b.	edent c. County		10	oc. City, Town or	Location						10d.	Inside Ci	ty Limits
ţ	5	MD F:	rederi	ick	M	lonrovia								1 ☐ Yes	2 🔀 No
Director	Ĭ .	10e. Street and Number					10f. Zip Cod	de			10g. Citiz	en of What	Country?	?	
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once. To Re Completed by Funeral Director		11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐ I		12. Was Dec Armed For 1 XYes If Yes, G Year or D	orces? 2 No live	r in U.S. 13	3. Was Decedent If Yes, specify 0 1 ☐ Yes 2 🔀		nic Origin? (Sp lexican, Puerto pec <i>ify:</i>	pecify Yes or No Rican, etc.)		4. Race - A Black, W Specify:			
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T S	Ď	Marshall		•	R.		Frey		Florence	ce			Br	e n ne	r
'		19a. Informant's Name/F	Relationship	(Type. Print)		I	iling Address (Str						e, Zip Co	ode)	
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State Registrar

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31. Date filed (Month, Day, Year)

OCT 26 2009

Division of Vital Records, P.O. Box 68760 thin 24 hours aft the Funeral DI mpletely filled in within 2 To the I complet

15H-4 State

teven 31. Date filed (Month, Day, Year) OCT 26

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (hem 23a) (Type, Print) EBER

and manner stated.

13424 Pennsylvania Ave Hagerstown, MD 2174

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 35463 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2009 Alton C. Graybill October 6:38 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Pennsylvania Months Days Hours Director 190-28-0708 74 1935 Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland | Anne Arundel West River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4804 Sudley Road 20778 USA within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. ğ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: White 3 Widowed 4 Divorced 9-23-59 Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) hould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Radiology Technician Radiology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Holmes C. Graybill Margaret M. Shaeffer should I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia M. Graybill/Wife Page 1 and 2 sh ment of Health a tant: If item 27 i 4804 Sudley Road, West River, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Southern Mem'l Gardens 10-21-09 Dunkirk, Maryland 4 ☐ Dongtion 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause (Disease or iinjury that initiated events Due to for as a consequence of The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician a s the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed been sign 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has b page 2 s autopsy perform this certificate 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 区 ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 🖵 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature an 29c. License number D58166 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 426 Marcalus, 3169 15 ravertu 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DCT 2 0 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 18 **Physician** 2009 1037 Betty Ann Grove /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Carroll Hospital Center Westminster Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Feb 25 1 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Days Min. 1□ M 🛠 🕏 F 78 Director 215-26-8567 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Carroll Westminster MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21157 USA 828 Spring Mills Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: <u>۾</u> Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 7 is marked other traumatic event, if 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Ann Barber Earl D. Fleming ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 870 Spring Mills Road Westminster, MD 21157 Pam Muller/granddaughter : If item 27 or other t altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 txDBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. Meadow Branch Cemetery 10/22/2009 Westminster, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Printed A Type Fally Home and Chapel, P.A. 21157 412 Washington Road Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ancreati disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lissass of imply that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ś 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗖 No 1 ☐ Yes 1 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

NI 30

State Registrar (Check only one)

29b. Signature and itle of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print) 11/1/10 M 31. Date filed (Month, Day, Year)

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 35465 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 6055 Prer x to be/ /Medical Facility, Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner In Mor)a If Under Year | If Under 24 Hrs 9. Birthplace (State or Foreign Country) (In yrs. last birthday) **Funeral** Months Days 1958 1 □ M 2 □ ¥ Hours 216-72-6955 51 **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at MD Allegany Cumberland Director 1 □ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 1538 Oldtown Manor Apt. D 21502 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 239 any injury or other traumatic event, the Natural once. Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married 1 □ Yes 2 □ No Specify ò 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housekeeping Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Priddy Louella (Collins) McDaniel ပ 19a. Informant's Name/Relationship (Type. Print)
Christopher DeVore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 804 Piedmont Avenue Cumberland MD 21502 son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/29/2009 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral/Service License 22. Name and Address of Full Eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one bause on each line.

Immediate Coulo (Final disease or continuous control of the control of th Approximate Interval Between Onset and Death Physician /Medical Due to (or es a consequence f) Examiner Due to (ur as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has I ector, page 2 s perform 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation ours after death. neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of perso

31. Date filed (Month, Day, Year)

NOV

4 2009

who completed cause of death (Item 23a) (Type, Print)

RES-OOL

St. Baltimore

OCTOB PR 27

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registral 35466 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Hitte Margaret Anne Kerr 200⁹ October 17, 8:45 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Bedford Court Skilled Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 F 14, Yrs Feb. 1925 Virgínia Director 578-24-1913 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 ☐ No Director Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20879 401 Christopher Avenue, T3 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 TXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 TNo Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Catholic Education High School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nathaniel Bell Kerr Sudie Armentrout 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Joseph Hitte/Husband 401 Christopher Avenue, T3, Gaithersburg, MD 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 26 Oct. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2009 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee anno Part 1. It ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1. Immediate Cause (Final **Physician** disease or condition resulting in death) Chronic Obstructive Lung Disease 10 years /Medical Due to (or as a consequence of) Examiner 7 years Coronary Artery Disease Sequentially list conditions, if any, bearing to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? Dav 5 Other (specify) 1 □Yes 2X□No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Hypertension 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a Hospital 29a, Certifier 1 🗷 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D18726 October 21, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arthur Schoengold, MD 18111 Prince Philip Drive, Olney, MD 20832

Registrar

State

31. Date filed (Month, Day, Year)

2009

3 Registrar's Signature

DHMH 17 Rev 1/2001

P.0.

			For State	State of Ma	aryland /		artment of F		and Ment			2009	35467
			Registrar 1. Decedent's Name (First, Middle, Last		11		•	- Jeann		ate of Dea	ıth		3. Time of Death
	Physicia Medic	cal	CHARLES 4a. Facility Name (if, not institution, give	SDGAR	HOF.	FMA	4b, Çity, Town, or	Leastion		onth O	93	2009	[845 M
)	Examir	ler	WOSHINSTON COUNTY	Mosp ital			HAgers	JOWN				inty of Death	
	Funeral Director		5. Social Security Number 220–28–3723 6. Se	x X M 2 □ F	(In yrs. last b	oirthday) Yrs.	If Undet 1 Year Months Days	If Under 2 Hours	24 Hrs. 8. D. Min. Ma	ate of Birtl Month, Day rch		9. Birth	nplace (State or Foreign ntry) yland
	and show dat	ρ	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation						10d. Inside City Limits
	r 28a-f notifie	Director	Maryland Washingt 10e. Street and Number	on	Hage	rsto	√n 10f. Zip Code				10 05	of What Cou	1 🔀 Yes 2 🗆 No
	n with the same of	Funeral	871 Pine Street				2174	0				S.A.	nury ?
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy finiup or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 🕱 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates.		I	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🛣 No	n, Mexican,				Race - Ameri Black, White, cify: wh	
21215-0036	within 72 hou giene. Ier than "nati i, the Medica	Be Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Seconday (0-12) 1 2			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) machinist				16b. Kind of Busin		facturer	
Maryland 2	d be filed w Mental Hyg arked othe itic event,	17. Father's Name (First, Middle, Last) P Howard Clifford Hoffman					18. Mother's Name (First, Middle, Maiden Blanche C. Kl:				Surname)		
	and 2 should Health and Me em 27 is mar ither traumati		19a. Informant's Name/Relationship (Ty) Gladys M. Hoffman				g Address (Street a						Code) 1740
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place Cedai	of Dispo- tery cren Law	sition (Name of natory or other place on Memori Par	គ្នំ1 O	ctober 2009	28,		on - City or T	own, State Maryland
Bal	Depar Impor any in		21. Signature of Foneral Service License	aili			Name and Addres			nnich Hag	Funer erstov	ral Ho vn, Ma	me ryland 21740
4	nysician/ Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line. a. AS4576	k_		r the mode of dying	g, such as c	cardiac or resp	iratory arre	est,		Approximate Interval Between Onset and Death
· Special Control	Examiner	ır	Sequentially list conditions.	Due til (or as a	consequence	e of):	E SHOCK	-					
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09	icate be executed g physician and is the burial-transit	dical E	resulting in death) Last	Due to (o∳rasa	consequend	e of):	(
876	tificate ng phy as th	ப ப	IF FEMALE:								1		
P.O. Box 687	23b. Was decedent pregnant in the past 12 months?					Fetal death 3 Ectopic pregnancy					23d. Date of delivery Month Day Year		
ds, P.0	r requires that the de t een signed by the should be detached	ed by P	Part II. Other significant conditions co	ntributing to death bu		g in the u	nderlying cause giv	en in Part I.	. 2			ontribute to t	he cause of death?
Division of Vital Records,	at 1. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Stage V Colon Concer 25. Was case referred to medical examiner? 1					i				ppsy findings available empletion of cause of			
ta	ician; certific ector,	Be	25. Was case referred to medical examiner?	lospital: 🔪 🏒					h (Check only o	one)			
<u>></u>	Phys r this ral dir	: To	1 ☐ Yes 2 No 7	1 Inpatier 28a. Date of injury	nt 2 🗆 ER/0	Outpatien Time of	t 3 DOA Othe	4 ∐ Nur	rsing Home 5		ence 6 🗆 0		0
ouo	tending leath. or: Afte the fune	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day,		injury	work'	? Yes 2 ☐ i	- 1	escribe no	w injury occ	urrea	
Divis	tal or At rs after o al Direct ed in by		4 Homicide determined	28e. Place of Injur building, etc.	y - At home, (Specify)	farm, stre	et, factory, office			ocation (St ity or Town		mber or Rura	l Route Number,
	To the Hospital or Attending Phywitin 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical	29a. Certifier (Check (Check only one) (Check only one) (Check only one)	cian: To the best of mer: On the basis of exa Practioner: To the b	amination and	l/or investi	gation, in my opinio	n, death occ	curred at the tin	ne, date an	d place, and	due to the ca	use(s) and manner stated.
	To t To t		29b. Signature and title of certifier				29c. License	number				ned (Month,	
5	H2+1		30. Name and address of person who compared BARON, M.D.	, 2SI E.	ath (Item 23a	MS	" HAROS	Town,	MD 21	1740	<i>' /</i>	•	
	Stat Registra	e ar	31. Date filed (Month, Day, Year) 6 20	32. R gistrar	's Signature		MARON			<u> </u>			
				person	~ /	- H							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 5:50 P M GAIL MARVIN HARRISON OCTOBER 15, 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 123 MAPLE AVENUE PRESTON CAROLINE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 X M 2 □ F Months Days Hours 85 218-16-2145 MARCH 15,1924 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 XYes 2 □ No PRESTON MARYLAND CAROLINE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 123 MAPLE AVENUE 21655 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 A Yes 2 1942 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: If Yes, Give Year or Dates: Specify: WHITE 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Rusiness/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PROGRAM SPECIALIST US GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GAIL BORDEN HARRISON EDITH PEARL CHANEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM HARRISON/SON PO BOX 622 PRESTON, MD 21655 20a. Method of Disposition 20b. Place of Disposition (Name of **EASTERN**em THORE her place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State VETERAN'S CEMETERY 4 Donation 5 Other (Specify) OCT.20,2009 HURLOCK, MD 21. Signature of Funeral Service Licensee FEELOWS HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 21601 R. MERCERON MADE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) respiratory Due to (or as a consequence): week

Physician /Medical Examiner

attending physician and for use as the burial-transit

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Certification: To

Medical

requires that the death certificate be executed

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Division of Vital Records,

Physician

/Medical

Examiner

10a State

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permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other trainment.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

Due to (or as a consequence of)

23d. Date of delivery Month Day Year

significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 I Inknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

pneumons Tis

23e. Did tobacco use contribute to the cause of death?

1 No 3 Probably 4 Unknown 24a. Was an autopsy performe

1□Yes 2XNo 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No

25. Was case referred to medical
examiner?
1 ∏ Yes 2 XNo
27 Manner of Death

1 Natural
2 Accident

3 Suicide

29a. Certifier

4 Homicide

5 Pending

6 Could not be determined

28a. Date of Injury (Month, Day, Year) investigation

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

3 Ectopic pregnancy

5 Other (specify)

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified

H0060785

29d. Date signed (Month, Day, Year)

pleted cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

State Registra

HIVA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Octobel /Medical Facility Name (If not institution, give street and number) Town, or Location of Death Examiner 4c County of Death If Under 24 Hrs. If Under 1 Year Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Director 185-24-4079 78 4/26/1931 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show ms 23a or 28a-f shor r must be notified a 1 ☐ Yes 2 ☑ No Directo MD Ellicott City Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? death with 4849 Bonnie View Ct. 21043 by Funeral USA ıral", or items 2 I Examiner mu 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene, important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event. the Landon one. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Smith ည Aileen Otterbein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul F. Humm / Husband 4849 Bonnie View Ct., Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) Ardent Cremation 10/20/2009 Hanover, MD 21. Signatu 3 of Funeral S M01411 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc 025 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cau e on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ear disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Dain to for as a nonsequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) P.O. 1 signed by the and be detached to 2X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s 1∐ Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes Other: 200 1 Inpatient မှ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

710 OBRECHT RD, SYKESVILLEMD 21784

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35470 Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1745 M **Physician** Huget **Eugene** oct 2009 18 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and 4b. City, Town, or Location of Death Examiner HOSP ita o (umbia Howard toward County General If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Funeral Days 385-32-4510 78 9/20/1931 Director MT Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the facilities at 1 ☐ Yes 2√ No Director MD Howard Ellicott City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4926 Evening Sky Ct. 21043 USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 XYes 2 No 1961-13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 [XXYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ▼No ģ 3 Widowed 4 Divorced 1980 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Professor 12 should be filed with and Mental Hygier 7 is marked other th Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leonard J. Huget Dorothy Mackey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau Barbara W. Huget / Wife 4926 Evening Sky Ct., Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Ardent Cremation 10/20/2009 4 ☐ Donation 5 ☐ Other (Specify) Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc M01411 21. Signature of Funeral Service Licensee Sour 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Fibrillation Immediate Cause (Final atrial chronic 2 years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the death certificate be executed burial-tran Due to (or as a consequence of): physician the burial Division of Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the a 9 Unknown 9 Unknown by s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð infarction 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed pernatremia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 sh 2 **N**No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D. ひのなり 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Snowden River Pkwy #301, Columbia, m 021045

Registrar DHMH 17 Rev 1/2001

State

MD

2009

Harry

31. Date filed (Mont

Registrar's Signature

09-08296 Nicole Hill

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

licole Hill	State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death Peo No. 2000 251.	-
Physician/	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death	\vdash
Medical Examiner		
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital 4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 214-08-1244 6. Sex 1 Age (In yrs. last birthday) 27 F 29 Yrs. 6. Sex 1 Age (In yrs. last birthday) 27 F 29 Yrs. 7. Age (In yrs. last birthday) 3. Birthplace (State or Months Days Hours Min. Jul 11, 1980 Foreign Maryland Country)	
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limi	its
A	Virginia Accomack Greenbackville 1 Tyes 2 X	
r death with the Maryland or items 23a or 28a-f she must be notified at once Funeral Director		
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Titem 27 is marked other than "matural", or items 23a or 28a-f shurtaumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Was Decedent Ever in U.S. 16. Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Yes 2 No specify: 17. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 18. Race - American Indian, Black, White, etc.	
ours af	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry	_
036 ithin 72 ho re than "no fedical Ex	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired) Convenience Cashier Store	
21215-0036 uld be filed within 72 hours al Mental Hygiene. marked other than "natural c event, the Medical Examin To Be Completed by	Unknown Pamela Michelle Hill	
MD 21 nd 2 should uth and Men m 27 is man aumatic ev	Pamela M. Stambaugh, mother 37371 Dreadnaught Dr, Greenbackville, VA 23356	
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Keysville Union Cem 20c. Location - City or Town, State 10/30/2009 Keymar, MD	
Balti permit. Departm Imports	22. Name and Address of Facility Myers—Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787	7
Physician /Medical	23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. So is the complete of the complete o	
caminer	Immediate Cause (Final disease or condition resulting in death) Seizure disorder complicated by drowning Due to (or as a consequence of):	
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury, that initiated	_
outed nd ransit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.	
50, te be executed sysician and burial - transit	☐ AMENDED 23a,27,28a-f,permE, g898 12/10/09 TT	
x 687(h certifica tending ph use as the ician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 23d. Date of delivery Month Day Year	
Boy the death hed for hed for hysi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	
ries that the signed by be detacled by P.O.	1 Yes 2 No 3 Probably 4 V Unknow	n
of Vital Records, P og Physician: The law requires t ther this certificate has been sign meral director, page 2 should be of TO Be Completed b.	24a. Was an autopsy findings availar autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No	
Vital Rec ysician: The his certificate director, page o Be Con	25. Was case referred to medical 26. Place of Death (Check only one)	
f Vita Physici er this caral direc	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other:	
on of onding Ph. ith. r. After to the functal ition: T		
Division o spiral or Attending nours after death nours after death effiled in by the function:	2 X Accident 3 Suicide 6 Could not be Could not be Could not be Seizure 10.24.09 19:32 pm Seizure 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Cor Town, State)	ity
Divis Hospital or / 24 hours after Funeral Dire stely filled in b		A
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Concerning 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Concerning Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
_		
MAL	30. Name and address of person who completed cause of death (Item 23a)	
	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar		

1. Decedent's Name (First, Middle, Last) **Physician** 15,_ William R Hunter 2009 2:12 a October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3899 Gold Hawk Mews Salisbury Wicomico 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 200-30-6000 74 Pennsylvania Director 08/16/1935 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural" or Name of the trainment. 10b. County 10c. City. Town or Location 10a State 10d. Inside City Limits Maryland Director Wicomico Salisbury 1 ☐ Yes 2 🗙 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3899 Gold Hawk Mews USA 21804 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give AlrForce Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married USA 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Hunter Ruby Kougher ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3899 Gold Hawk mews, Salisbury, MD 21804 Diana Hunter/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Buría! 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 10/16/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service Licensee ²² Name and Address of Facility Holloway Funeral Home Professional Association an 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 10 davs disease or condition resulting in death) Aspiration Pneumonia /Medical Due to (or as a consequence of) Examiner Parkinson's Disease Sequentially list conditions, if any least to be a list of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and particular in the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Chronic Obstructive pulmonary disease 1 ☐ Yes 23 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 😿 Residence 6 Nother (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) a. Wennich, m.D. Oct. 15,2009 30. Name and address of per s who completed cause of death (Item 23a) (Type, Print) 1346 G. DIVISION ST SALISBURY WENRICH, M.D.

State Registr<u>ar</u> 32. Registrar's Signature

Lenus

			For	State of Ma	aryland / [Departme	ent of He	ealth and N	lental Hy	/giene		
_			1 - State Registrar			Certifica	ate of D	eath		Reg. No.	2009	35473
	Physic	ion	1. Decedent's Name (First, Middle, L	ast)			-,-,		2. Date of D		2002	3. Time of Death
	/Medi		Elizabeth	P.		H	learn		Month 1 C	- 19	Year	1: 25 AM
	Exami		4a. Facility Name (If not institution, g	,		4b. Cit	y, Town, or L	ocation of Death		4c.	County of Death	
			Coastal Hosp	pice at the	Lake	Sc	disb.	N. Nr.		(nicom	100
	Funeral		Social Security Number 6.		(In yrs. last bir		er 1 Year	If Under 24 Hrs.	8. Date of Bi		9. Birthr	place (State or Foreign
	Director		213-14-7107	1□M 2\ F	87	Yrs. Month:	s Days	Hours Min.	10-22	'=192	1 Cour	vland
	Dr.	7	Usual Residence of Decedent						10 22		<u> </u>	yrand
	rylar	-	10a. State 10b. County		10c. City, Towr	or Location					1	0d. Inside City Limits
	e Ma ka-f	양	MD Wicon	mico	Salis	burv						1 ☐ Yes 2 ☑ No
	17 th	Director	10e. Street and Number				ip Code			10g. Citiz	zen of What Cour	ntry?
	th wi		31755 Mt. Hermon	Road			2180)4		II	SA	
	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examinational by notified at	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Dec	edent of Hisr	anic Origin? (Sn	ecify Yes or N		14. Race - Americ	
ဖွ	after or It		1 Never Married 2 Married	1 ∐Yes 2 📉 No	О			Mexican, Puerto	Hican, etc.)		Black, White,	
, <u>6</u>	ours	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes	2 X 1N0	Specify:			Specify: Whi	te
2 15	72 hc	Completed	15. Decedent's E (Specify only highest g	Education	16a.	Decedent's Us	ual Occupati	on		16b. Kir	nd of Business/Ind	dustry
2 2	within iene. than "	혈	Elementary/Secondary (0-12)	College (1-4or 5+	F)	life. DO NOT	rork done dur use retired)	ring most of worki	ng			
2 7	d wil	Ş	5		′	omemake	r				Own Home	
T P	be filed Ital Hygi od other event, II	Be (17. Father's Name (First, Middle, Las	t)			1	8. Mother's Name	(First, Middle			
<u>a</u> .	Aenta Aenta rked tic e	P P	Erving	Iohi	nson		N	Tora			Drvd	on
ト ? ハキear へ Maryland 21215-0036	should and Men s marke umatic		19a. Informant's Name/Relationship			Mailing Addres			al Route Numb	er. City or	Town, State, Zip	
Σ۶	1 and 2 Health a em 27 is		Rebecca Collison	- Daughter							Marylan	•
F e	es 1 a of He fitem		20a. Method of Disposition	244811441	20b. Place of	Disposition (Na y, crematory or	ame of		ate		cation - City or To	
انده اندان altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinational be notified at once.		1 X Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec	Removal from State	1						,	
رم Iltim	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lice		W1COM1C	O Memor	rial P					<u>Maryland</u>
E .: Ba	permit. Departr Imports any Infu			00 000	.)			. 100			al Home	
m -			23a Part 1 Enter the disease or con	policy is a that accord to	the death Day						Marylan	
			23a. Part 1. Enter the disease, or conshock, or heart failure. List only	one use on each line	ene deam. Don 9.	ot enter the mo	ae or aying,	such as cardiac o	or respiratory a	irrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. END ST	ACIR	CAR	Dion	YOPA T	14 /			Oriset and Death
	/Medical Examiner		Testiting in death)	Due to (or as a	consequence of							
		<u>.</u>	Sequentially list conditions, if any, leading to immediate	b								
	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence o	f):						
	ecut and -tran	Examiner	that initiated events resulting in death) Last	c								
60,	be eg			Due to (or as a	consequence o	T):						
68760,	ficate be executed physician and s the burial-transit	edical		_d								
-	leath certific attending p	Me	IF FEMALE;		-					- 1		
Вох	ath c ttenc or us	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	f pregnancy	3 🗆 Ectopic	nregnancy			2	3d. Date of delive	,
0	e de the a red fo	sici	1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at t g ☐ Unknown	time of death	5 Other (s					Month	Day Year
Р.	at th	Physician/Me	g □ Unknowh						-			
	es th igner	þ	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying	cause given i	n Part I.	23e. Did t	obacco us	e contribute to th	e cause of death?
ord	equir	Completed							10	Yes 2	No 3 ☐ Prob	ably 4 🗌 Unknown
S	law r as be 2 sh	ple							24a. Was	an	24b. Were autor	osy findings available appletion of cause of
Œ	The ate has age	E								rmed? _ I	death?	
ta	lan: rtiflica tor, p	Be C	25. Was case referred to medical					6. Place of Death	1 Yes	21110	1 ☐ Yes	2 ANO
>	ysici is cel		examiner? 1 ☐ Yes 2 ☐ No	Hospital:	t 2 ER/Out	nationt 2 🗆 D	Othory				12.	11-000000
ō	a Ph	盲	27. Manaer of eath	28a. Date of Injury (Month, Day,			28c. Injury at Work?	4 ☐ Nursing Hon	ne 5 ☐ Resi 28d. Describe l		Other (Specify	TOSPICE
Ö	th. : Aft	ţ	Natural 5 Pending investigatio		Year) In	ury M		2 🗆 No		1011,017	00001100	
Division of Vital Records,	Atter r dea sctor	ţic	3 ☐ Suicide 6 ☐ Could not b		y - At home, farr	I n. street. factor			8f Location (Street and	Number or Rural	Pouto Number
ō	affer affe	Certification: To	4 ☐ Homicide determined	building, etc.	(Specify)		,	1	City or Tov	vn, State)	rvumber of riular	noute Number,
	spita nours nera / fille		29a. Certifier Certifying Pl	hysician: To the best of	my knowledge.	death occurred	at the time.	date and place a	and due to the	Called(e)	and manner as et	atad
	To the Hospital or Attending Physician: The law requires that the death certii within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medical Examone)	miner: On the basis of e and manner state	examination and	or investigation	n, in my opini	ion, death occurre	ed at the time,	date and p	place, and due to	the cause(s)
	Withir To th	Me	29b. Signature and title of certifier			29	c. License nu	ımber		29d. Date	signed (Month, E	Pay, Year)
							000	58410			0/19/09	
	KAN	,	30. Name and address of person who	completed cause of dea	ath (Item 23a) /T	vne Print\		58411			10107	
			CHURN WARY	P. BO		2 (Aci	Bung		~	7 : 72	7
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's		1 /2 /		5007		4)	0100	
40	Registra		OCT 0 1/200	0	D. A	ask						

			1 - For State Registrar	State of	Marylan	nd / D	epartment of Certificate	of Heal of Dea	lth and i a <i>th</i>	Mental Hy	/giene Reg. No	2009	35474
	Physic	ian	Decedent's Name (First, a George	Middle, Last)	layne					2. Date of Do Month		y Year	3. Time of Death
	/Medi Examir			itution, give street and numb			4b. City, Tow	n, or Loca	ition of Death	10	/5 4c	. County of Death	10:50 AM
1				aspice at	the	Lak	e 501	1.5 E	DUry		1	Nicon	
	Funeral Director		5. Social Security Number 372–36–3035	1 🔀 M 2 🗆 F	Age (In yrs. 72		nday) If Under 1 Yours. Months D		nder 24 Hrs. urs Min.	8. Date of Bi (Month, D 05/05/	rth <i>av. Y</i> e <i>ar)</i>	9. Birth	nplace (State or Foreign untry) higan
	/land		Usual Residence of Decede 10a. State 10b. Co		10c. Cit	ty, Town	or Location						10d. Inside City Limits
	e Mary ta-f sh	ctor	Maryland Wi	comico	S	alis	bury						1 ☐ Yes 2 🙀 No
	death with the Maryland ms 23a or 28a-f show	al Director	10e. Street and Number 1514 Wood	lland Road			10f. Zip Co	de .801			10g. Cit	izen of What Cou USA	untry?
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Examiner must be tradified at Ansa.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ 3 □ Widowed 4 □ Divo	If Yes Give	s? ∑ No	.S.	13. Was Decedent If Yes, specify 1 □Yes 2 🔀		ic Origin? (Sexican, Puerto	pecify Yes or No Rican, etc.)	D-	14. Race - Amer Black, White Specify: W	
George Hayne Baltimore, Maryland 24215-0036	72 hou "nature	Completed	15. Dec (Specify only i	edent's Education nighest grade completed)		16a. [Decedent's Usual O Give kind of work de life. DO NOT use re	cupation one during	most of worl	king	16b. K	ind of Business/li	ndustry
25	within giene. r than	omp	Elementary/Secondary (0-	12) College (1-4d	or 5+)	1	life. DO NOT use re YSICIST_	tired)			N	ASA	
Hand in	be filectal Hygen double	Be C	17. Father's Name (First, Mic	ddle, Last)			ybrorbc_	18. 1	nother's Nam	ne (First, Middle			
Ya	should I and Men s marker umatic	٩	Don William 19a. Informant's Name/Rela			101				es Swai			
Ma Ma	and 2 shalth an 127 is 1		Kathleen Ha	1 1 27			Mailing Address <i>(St.</i> .514 Woodl						ip Code)
George Iore, Maryla	ges 1 ant of He		20a. Method of Disposition 1 ☐ Burial 2 【 Crema	tion 3 🗆 Removal from Sta	20b. P	Place of E cemetery,	Disposition (Name of crematory or other	f place)	1	Date	20c. Lo	ocation - City or T	own, State
Itim	nit. Page artment ortant: If		4 □ Donation 5 □ Oth	er (Specify)	Sal	isbu	ry Cremat	-	10/1			isbury,	
Ba	permit. Departr Imports any inju	4	Navie 7	Compson	SCF	SP	Hollowa 501 Snc	y Fur w Hi	neral :	Home Pro	ofes ourv	sional A , MD 218	ssociation
			snock, or neart failure.	e, or complications that caus List only one cause on each	ed the death		ot enter the mode of	dying, suc	h as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		TRO		C CATR	MAC		CLIZA	2051	S	Onset and Death
-	Examiner		. Sequentially list anditions	bue to (or	as a consequ	uence or,):						
	ted 1sit	Examiner	Sequentially list conditions, it can be caused by the cause. Enter Underlying Cause (Disease or injury that initiated events	Sue to (or	as a surissiqu	usnec of)							
o,	execu an and rial-tra	Exar	that initiated events resulting in death) Last	c Due to (or a	as a consequ	uence of)):						
68760,	ifficate be executed g physician and as the burial-transit	edical		d				_					
Вох 6	leath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnan in the past 12 months?	t 23c. If yes, outcor			3 ☐ Ectopic pregn	ancy				23d. Date of deliv	
0	at the de by the a tached fi	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnan 9 ☐ Unknowi		leath	5 ☐ Other (specify)				Month	Day Year
ds, P.	es tha	þ	Part II. Other significant cor	nditions contributing to death	but not resu	ulting in th	he underlying cause	given in P	art I.	23e. Did t		0	the cause of death?
Division of Vital Records,	aw requin as been si 2 should I	Completed								24a. Was		24b. Were auto	opsy findings available
E E	sician: The law certificate has rector, page 2 s	Com								autop perfo 1 □ Yes	osy rmed2 24 No	death?	ompletion of cause of
Vita	sician: certific irector,	Be	25. Was case referred to me examiner? 1 ☐ Yes 2 ☐ No	Hospital:				Othorn		h (Check only o			
0 ر	ding Phys h. After this funeral dir	n: To	27. Manner of Death	28a. Date of Ir		28b. Tim Inju	atient 3 DOA	jury at Vork?	Nursing Ho	ome 5 Resident		Other (Speci	ty Hospicz
sior	or Attending after death. Director: After in by the funer	catic	2 Accident inv	vestigation			М .	□Yes	2 □ No				
Divi	al or Al after of Direct d in by	Certification: To		termined 286. Place of I	njury - At ho etc. (Specify	me, farm	n, street, factory, offic	e		28f. Location (S City or Tox	Street and vn, State,	d Number or Run	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Cert (Check only 2 Med	ifying Physician: To the be- ical Examiner: On the basis and manner	of examinat	wledge, o	death occurred at the or investigation, in n	e time, da	te and place, death occur	and due to the red at the time,	cause(s) date and	and manner as place, and due t	stated. o the cause(s)
	To the within To the comple	Me	29b. Signature and title of ce				29c. Lic	ense numb	per		29d. Dat	e signed (Month,	Day, Year)
	10						6	2005	174	0	/	0/15/0	9
	'8N		30. Name and address of per & HULAW (son who completed cause of	death (Item	23a) (Ty	29c. Lic ppe, Print) 1733	CL	(i'an	10:0		10 0:	802
	Stat	te	31. Date filed (Month, Day, Y	ear) 32. Regis	trar's Signat	ure	1733	3/1	4136	7	u	4 . [80 _
	Registra	ar	OCT	20 2009 Am	wa	A.	garke						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Stephen Hammaker State of Maryland / Department of Health and Mental Hygiene 2009 35475 1- For State Certificate of Death Reg. No Registrar . Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Month Medical Examiner 1640 hrs Stephen Anson Hammaker October 28, 2009 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 611 Wye Oak Drive Fruitland Wicomico **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country Months Days Hours Director 177-68-9693 1 X M 2 F Nov. 19, 1981 Pennsylvania Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show MD Wicomico 1 Yes 2X No Fruitland notified at once, with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 611 Wye Oak Drive 21826 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, nust be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 X No Yes Divorced Widowed . Give Yea Yes 2 X No specify: White Specify permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 3 Unemployed 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Mark Hammaker Be Suzanne West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dana Hammaker/Wife 611 Wye Oak Drive, Fruitland, MD 21826 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place)
Willow Grove 1 X Burial 2 Cremation 3 X Removal from State Nov. Harrisburg, PA 2009 Donation 5 Other Specify Cemetery | 22. Name and Address of Facility 21. Signature of Furteral Service License Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 Suche 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Narcotic (metahdone and oxycodone) intoxication Immediate Cause (Final disease camine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. and Physician/Medical tending physician a use as the burial -AMENDED 23a,27,28a-f per ME g897 11/34/09 TT X UNPENDED Box 68760, IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) detached for 1 Yes 2 No 9 Unknown g Unknown by the <u>Р</u> О Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I ğ 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, ificate has been si 24a Was an 24b. Were autonsy findings available autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 No 1 Yes 2 No 25. Was case referred to medical Division of Vital director, 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other 4 this Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene ို 1 V Yes No funeral After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Yes 2 X No Pending To the Funeral Director: completely filled in by the 10/28/09 unk unk 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide orTown, State)
Wye Oak Dr Fruitland, MD determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Wedical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

29c. License number

O.C.M.F.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

October 29, 2009

29b. Signature and title of certifie

Laron Locke MD.

31. Date filed (Month

and manner stated

Assistant Medical Examiner

istrar's Signature

39. Name and address of person who completed cause of death (Item 23a)

DK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Month Year **Physician** рМ 21, 3:00 Iseminger October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Hagerstown

| House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | Broadmore Senior Living Washington Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year) Months 1 □ M 2 🖫 F 87 186-14-6117 1922 Pennsylvania Director Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Event in a coust be multified at 1 ☐ Yes 2 ☐ No Directo Maryland Washington Funkstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23 Frederick Road 21734 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 No 1945-1 Yes 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Completed by 3 ₩ Widowed 4 Divorced white Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7; th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) nurse hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clyde MacAfee Bridget Splett ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is nr any injury or other traun once. Box 479, Funkstown, Maryland 21734 Bertrand Iseminger son P.O. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory 10-23-09 Hagerstown, Maryland 22. Name and Address of FacilityMinnich Funeral Home 21. Signature of Funeral Service Licensee 16lil 415 E. Wilson Blvd., Hagerstown, Maryland 21740 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Athenosterozis **Physician** JEARS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner requires that the death certificate be executed attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregrant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 icate has been sig , page 2 should b 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 🗌 Yes 2 [or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 | Inpatient Certification: To 6 Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 29a, Certifies Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 29b. Signature and title of pertifier who completed cause of death (Item 23a) (Type, Print) 30. Name erson dreal Campus Suite 130

5H 3+1 State

31. Date filed (Month OC.

1e

gistrar's Signature

32

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 35478 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Estreilla Kadoch October 21, 2009 10:05 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 1 □ M 2 K F Months Days Director 217-46-9613 92 12, October 1917 Morocco Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show MDMontgomery Rockville Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6121 Montrose Road 20852 Completed by Funeral United States permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Examinations. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. White 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 □ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dressmaker Garment 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Abraham Benayoun Mahita Abitol ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michel Cadeaux - son 5311 Acacia Avenue Bethesda MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt Lebanon Cemetery 4 Donation 5 Dother (Specify) 10/22/2009 Adelphi, MD 21. Signature of Fun 22. Name and Address of Eacility
Edward Sagel Funeral Direction Inc.
1091 Rockville Pike Rockville MD 20852 M01163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** rulemonia. disease or condition resulting in death) /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Month 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year 5 Other (specify) the detached 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 □No 2/2/No 25. Was case referred to medical Be examiner?

Examiner Division of Vital Records, P.O. Box 68760, hadoch, Estrella 10/21/09

altimore, Maryland 21215-0036

certificate မ After Certification: Hospital or Attending death. within 24 hours after death

To the Funeral Director:
completely filled in by the

26. Place of Death (Check only one) 1 ☐ Yes 2 No

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending investigation 6 ☐Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

 Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature ar

27. Manner of Death

1 Natural

2 ☐ Accident

4 Homicide

3 ☐ Suicide

29a, Certifier

29c. License number

29d. Date signed (Month, Day, Year)

10

30. Name and ss of person who completed cause of death (Item 23a) (Type, Print) Atul Rohatgi MD 8600 Old Georgetown Road Bethesda MD 20814

and manner stated.

determined

State Registrar

Medical

31. Date filed (Month, Day, Year) OCT 22 2009



			For State Registrar	State of M	aryland	d / Depa <i>Cer</i>	artment of I tificate of I	Health and Death	d Mental Hy	giene Reg. No. 20	09	35479
		,	Decedent's Name (First, Middle, Las	:t)					2. Date of Dea	ath		3. Time of Death
	Physicia Medic		JOHN DE	LBERT	101	IES			Month OCTOBER	Day 2. 35	Year 2009	1:27AM
	Examin	er	4a. Facility Name (if not institution, give			_	4b. City, Town, c			4c, County		
			Washington Co		<u>'</u>		Hage If Under 1 Year	rstown			shing	
	Funeral Director			ex DXM2□F	e (in yrs. ia 73	st birthday) Yrs.	Months Days		Irs. 8. Date of Birt lin. August	8, 1936	9. Birthp	place (State or Foreign atry) Land
			Usual Residence of Decedent						730	0,2000		- y 2 a 11 a
	yland f sho ed at	tor	10a. State 10b. County		1	, Town or Loc					1	10d. Inside City Limits
	e Mar 28a- notifi	Director	Maryland Washin	gcon		lagers						1 Yes 2X No
	ith th	rall	20532 Jeffers	on Dlud			10f. Zip Code	4.0		10g. Citizen of V		itry?
	ems arm	Funeral	11. Marital Status	12. Was Decedent B	Ever in U.S	. 13. V	217		(Specify Yes or No-		e - Americ	can Indian
တ္က	ter de , or it	by F	1 Never Married 2 X Married	Armed Forces?	No	If	Yes, specify Cuba	an, Mexican, Pu	erto Rican, etc.)	Blac	k, White,	etc.
003	urs af tural" al Exa		3 Widowed 4 Divorced	If Yes, Give Year or Dates.			Yes 2 X No			Specify:	Whi	Lte
15-	72 ho n "na'	Completed	15. Decedent's E (Specify only highest gra			(Give k	ent's Usual Occup ind of work done ONOT use retired)	during most of v	vorking	16b. Kind of Bu	usiness Inc	dustry
21215-0036	vithin liene. rr tha: the N		Elementary/Seconday (0-12)	College (1-4 or 5	5+)		neer			Mfq. M	ack	Trucks
פ	filed within 72 hours after death with the Maryland the Hygiene. Hygiene. A thygiene do ther than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.		17. Father's Name (First, Middle, Last)					18. Mother's I	Name (First, Middle,			
ylaı	ld be fil Mental Iarked atic eve	욘	William R	ussell	Jo	nes		Kat	<u>herine</u>	Kauff	man	Leckron
Maryland	2 should be fil Ith and Mental 27 is marked (traumatic ev		19a. Informant's Name/Relationship (7) Betty S. Jones	_{/ре, Print)} Wife					Rural Route Number			
	nd Fea		20a. Method of Disposition	MITE	20b. Pl		Sition (Name of	OU BIAG	,, Hagers	20c. Location -		
ē	Page 1 nent of ant: If i		1 ★ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		ce	emetery crem	atory or other places Cemete	rv 10-			-	, Maryland
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ott	40	21. Signature of Funeral Service Licens	ee /								, ridzy zdria
m	8 8 E 8	0.0	A. hoel Br			4	O East A	ntietam	n Funeral Street,	Home, Hagersto	inc. Dwn,	Md. 21740
			23a. Part 1. Enter the disease, or companies shock, or heart failure. List only or			. Do not ente	r the mode of dyin	g, such as card	liac or respiratory arr	est,		Approximate Interval Between
P	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	ING	CAN	ion					Onset and Death
The ser	Examiner		issuming in addition					. /	can co	1		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a			DUET	b Lugus	1 CAN CO			
3	ured id ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	CHRON	ic	GBST	eu CTIVE	Pulmo	WALT DI	BAJE		
	be executed sician and burial-transi	al E)	resulting in death) Last	Due to (or as a		,						
Ø :	ate ohys the	edical		dt	+70	0+6	NIA				_	
89	certificate inding physuse as the	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d Dat	te of delive	an,
Box	earn c	icia	in the past 12 months?	4 Pregnant a	2 ∐ Fetal t time of de	death 3 Leath 5 Leath	Ectopic pregnand Other (specify) _	cy		Moi		Day Year
0.	by the tacher	Physician/M	9 Unknown	9 Unknown								
Р.О	igned be de	ρ	Part II. Other significant conditions co	Intributing to death b	ut not resu	ılting in the ur	nderlying cause gi	ven in Part I,				ne cause of death?
rds	equire	eted										bably 4 🗌 Unknown
O O	has the	Completed							24a. Was a autop	sy p	Vere autop prior to cor feath?	psy findings available mpletion of cause of
ř	n: ine fficate or, pag		25. Was case referred to medical				26 P	age of Death (C	_		Yes	2 🗌 No
i ta	/sicial	To Be	evaminer?	Hospital:	ent 2 F	R/Outpatien	Lou	ace of Death (C	g Home 5 Resid	6 T Othe	Canalist	
ō	ig Pin ter thi		27. Manner of Death	28a. Date of injui	ry :	28b. Time of injury	28c. Injur	y at		ow injury occurre		,
0	endir leath. or: Af the ful	ifica	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		, , , , , ,	,		Yes 2 No				
Division of Vital Records,	or An after d Direct in by	Certificate:	4 Homicide determined	28e. Place of Inju building, etc		ne, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	r or Rural	Route Number,
ב ב	spiral neral I		29a. Certifier 1 X Certifying Phys	sician: To the best of	my knowle	edge, death o	ccured at the time	, date and place	e, and due to the cau	se(s) and manne	er as state	d.
1	to the hospital or Attending Prysician: the law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medical Exami only one) 3 Certifying Nurs	ner: On the basis of ex	xamination	and/or investi	gation, in my opinio	on, death occurre	ed at the time, date a	nd place, and due	to the cau	use(s) and manner stated.
,	To 1		29b. Signature and title of certifier				29c. License			29d. Date signed		Day, Year)
		ļ	ZIM.			00.1=		52006		10/23/0	9	
H	4-4		30. Name and address of person who c				*		57. Huz	GRITOW,		10
	Stat	е	31. Date filed (Month, Day, Year) 6 2	32. Registra	r's Signatu	ire	ales	- [/]	□ [· · · · V] V]	- 11 DW	<u> </u>	(1/)
	Registra	ır	UU 25 21	009 Sener	u,	A. 10.	ake					

			For State Registrar	State of Marylar		artment of He ctificate of D			iene eg. No.		
21	waisla		Decedent's Name (First, Middle, Last)					2. Date of Deat Month	n 20	0.9	3. 3m514aB ()
	nysicia Medic		THOMAS JUDGE					OCTOBER		009	12:10 A ^M
E)	kamin	er	4a. Facility Name (If not institution, give si 4734 SAILORS RETRE			4b. City, Town, or L OXFORD	ocation of Death	1	4c. County		
	neral ector		219-20-1300	M 2□F 7. Age (In yrs.	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JULY 26,	Year)	9. Birthpl Coun Mary	* /
and		ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Lo	cation				10	Od. Inside City Limits
Mary	lied a	ţoţ	MD TALBOT	0.	XFORD						1 □Yes 2 🔏 No
ith the	Bernot	Director	10e. Street and Number	1		10f. Zip Code		1:	0g. Citizen of V	What Coun	try?
ath w	Tight.		4734 SAILORS RETRE			21654			USA		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Dipoparant: If then 27 is marked other than "patural" or items 23a or 28a.f show	Evar-inst.	by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	 Was Decedent Ever in U Armed Forces? Types 2 ☐ No If Yes, Give Year or Dates: 		Vas Decedent of His fYes, specify Cuban □Yes 2 X No	panic Origin? (S), Mexican, Puerto	o Rican, etc.)		e - America ck, White, e	
72 ho	dical	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)	(Give	lent's Usual Occupat kind of work done du		king	16b. Kind of Bu	usiness/Ind	lustry
within ene.	the Mile	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	Pil	OO NOT use retired)			Auri	ation	
filed Hygin	ent, 1	Be C	17. Father's Name (First, Middle, Last)	<u>.</u>	111		18. Mother's Nam	ne (First, Middle, N			
Vlar	atic e	일	Arthur Judge				Filex2	ena Phel	ps		
Maryland of 2 should be file th and Mental Hy	ran		19a. Informant's Name/Relationship (Typ	e. Print)		g Address (Street ar					ŕ
1 and 1 and Healt	other		ANN JUDGE/WIFE 20a. Method of Disposition	20b.		SATLORS R			ORD, MD 20c. Location -		
mor	y or		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	cemetery, cren FORD CE	sition (Name of natory or other place)	i i	5/2009	OXFORD	•	
Baltimore, permit. Pages 1 ar Department of Hee	any inju once.		21. Signature of Funeral Service Licenses		FF	Name and Address LLOWS, HE O SOUTH H	of Facility LFENBEIN	N & NEWNA	M FUNE	RAL H	OME, P.A.
			23a. Part I. Enter the disease, or complic shock, or heart failure. List only one	ations the caused the deal						<u>D 210</u>	Approximate Interval Between
Physic	cian		Immediate Cause (Final disease or condition	Wishte	te C	ancer					Onset and Death
/Med Exam			resulting in death)	Due to (or as a consec							
Aum		ř.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	mence of):						
uted	ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	540 (5) (6) 40 4 5011505	,401100 01).						
O, e exec ian an	s the burial-transit	Exa	resulting in death) Last	Due to (or as a consec	quence of):						
68760, ificate be ex	the bu	edical	d.			.					
erriffic		Me	IF FEMALE:	c. If yes, outcome of pregn	ancy						
o e e	tached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 9 ☐ Unknown	aldeath 3□	Ectopic pregnancy Other (specify)				te of delive onth	ry Day Year
S, P.		by P	Part II. Other significant conditions conti	_	sulting in the ur	derlying cause given	in Part I.	23e. Did tob	acco use cont	ribute to th	e cause of death?
cord require been si	should		Multiple M	jeloma				1 □ Ye	s 2 No	3 Prob	ably 4 TUnknown
Rec e law has b	CI	Completed						24a. Was ar autops	v 🖈 1	prior to con	osy findings available npletion of cause of
Vital F slcian: Th certificate	or, pag		25. Was case referred to medical						No	death? 1 ∐Yes	2 □ No
' Vii y slcia s cert	director, page	o Be	examiner?	spital: 1 ☐ Inpatient 2 ☐	l EB/Outpatien	Othor	,	th <i>(Check only one</i> ome 5 X Reside	,	Pr (Specifi	<i>d</i>
n of ng Phi fter thi		on: To	27. Mann of Death 1 ✓ latural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury a		28d. Describe ho			· · · · · · · · · · · · · · · · · · ·
VISIOI Attendir death. ctor: A	the fu	catic	2 ☐ Accident investigation			M 1 □Y€	es 2□No				
Division of Vital Records, To the Hospital or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been signed.	lled in by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)			28f. Location (St. City or Town	, State)		
Hosp 24 hot Fune	etely fi	Medical	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examine	cian: To the best of my known: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the time restigation, in my opi	e, date and place nion, death occu	, and due to the ca rred at the time, da	ause(s) and ma ate and place,	anner as st and due to	ated. the cause(s)
To the vithin	compl	ğ -	29b. Signature and title of certifier			29c. License	number	29	d. Date signe	d (Month) L	Day, Year)
			· Davidt	Snur		139	811		10/14	4 1	09
OL A			30. Name and address of person who com	pleted cause of death (Iter	m 23a) (Type, F	Print)	2 - 1	# > -	. C-	- 1	10 - 1
RK 8	Stat	0	31. Date filed (Month, Day, Year)	32. Begistrar's Signa	ature 32)1 lal	Driv	e 30	1 20	SIU	ind
De	Stat	_	OCT 1 6 200	10 4	h 1	2. 26 1					

			1 - For State of Maryland / Department / Department / Department / Department / Department / Department / Department / De	artment of Health and Mo		ne No. 2009 35482
	Physici	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	/Media	cal	Dawn Lila Johnson 4a. Facility Name (If not institution, give street and number)		Oct. 20, 20	09 1:45 P M
	Examir	ner	Fort Washington Hospital	4b. City, Town, or Location of Death Fort Washington		Ac. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Yea	Prince Georges 9. Birthplace (State or Foreign Country)
	Director		509-70-0978 1		Sept. 25,	
	/land ow est		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	a-f sh	ctor	MD Prince Georges Accokee	ek		1 □Yes 2√ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
	s 23a			20607	US	A
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminer must be notified at once.	by Funeral		Was Decedent of Hispanic Origin? (Spec If Yes, specity Cuban, Mexican, Puerto R 1 ☐ Yes 2 ☐ No Specify:	eify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Maryland 21215-0036	72 hou natura dical E	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	dent's Usual Occupation	16b.	Kind of Business/Industry
121	vithin the. than "	mple	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired)		
d 2	filed v Hygie other 1	ပ္ပို့	17. Father's Name (First, Middle, Last)	tive Secretary 18. Mother's Name		Government
lan	ild be fental rked o	To Be	Joseph Johnson, Sr.		Katherine	,
lary	shou and M is mai	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mailin	ng Address (Street and Number or Rural	Route Number, City	or Town, State, Zip Code)
	and and man man man man man man man man man man			Cottongrass Street	, Waldorf	, MD 20603
Baltimore,	Pages 1 nent of H int: If Itel iry or otl		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposements, cremitation and complete states are considered as a second state.	osition (Name of Da matory or other place)	te 20c.	Location - City or Town, State
Ħ H	it. Pa intmer intant: njury		4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Service upons e	emetery 10-27	_2009 Top	eka, Kansas
Ba	Depa Impo any Ir once		Judith Show 650	03 Old Branch Ave., Tem	ple Hills, I	nson Funeral Home P. A. MD 20748
		y 93	23a. Pati 1 Enter the disease, it complications that caused the death. Do not enter it is only one cause on each line.	7	respiratory arrest,	Approximate Interval Between Onset and Death
}	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	heat lance		٠ ٢٧٠
	Examiner					,
- 4	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Liter Undertying Cause (Disease or injury			
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C			
8760,	be ey	dical E	bue to (or as a consequence or):			
9	ificate g phys	edic	d			
Вох	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
о <u>.</u>	ires that the de signed by the a I be detached I		Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I	23e Did tobacco	use contribute to the cause of death?
ords	w requires been sign should be	eted by			1 ☐ Yes	/
Vital Records,		Completed	25. Was case referred to medical		24a. Was an autopsy performed? 1□ Yes 2□N	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2☐ No
>	ysicia is cert directe	To Be	examiner? 1 Yes 2 No Hospital: Inpatient 2 ER/Outpatient	26. Place of Death (6 □Other (Specify)
0 0	ding Ph h. After thi funeral		27. Manner of Death 28a. Date of Injury 28b. Time of		d. Describe how inju	
Sio	Attendir death. ctor: Al	atio	2 Accident investigation	M 1 Yes 2 No		
Division or	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, stre building, etc. (Specify)	eet, factory, office 28	f. Location (Street a City or Town, Stat	and Number or Rural Roufe Number, te)
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	ledical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death and manner stated.	occurred at the time, date and place, an restigation, in my opinion, death occurred	d due to the cause(at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
	Vith Vith Com	Σ	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
			1/1/8	1045365	/	0-20-9
2	8		(Check only one) 2	Print) /i-ing stand #101	font ha	syge ma 2010
	Stat Registra	ar	31. Date filed (Month, Day, Year) OCT 2 2 2009 Lune S. Agarla			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) Date of Death Month 2009 2:10 P M October Katherine Jane Kershner 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Williamsport Washington Homewood Retirement Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 7,1929 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 □ M 2 🛛 F Months Days Hours Min. 80 Maryland 220-26-9670 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits XYes 2 □ No Williamsport <u>Maryland</u> Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 Springfield Lane 21795 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Goldie Louise Griffith Charles Clarence Reckard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Kershner - Husband 22 Springfield Lane Williamsport, Maryland 21795 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ₩Burial 2 Cremation 3 Removal from State Oakland Cemetery Oct.26,2009 Oakland, Maryland 4 Donatton 5 Other (Specify) Osborne ArmeradyHome, P.A. eture of Funeral Service Licensee 425 S. Conococheague St. Williamsport, MD 21795 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failu Imm diate Cause (Final disease or condition resulting in death) aspiration pneumonia 3da Du to (or as a consequence of): senile dementio vears Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nunsequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 moortis? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part <mark>II. Other sIgnificant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 🖸 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy loury or other traumatic event, the Profical Eventiciant be retified at once.

Baltimore, Maryland 21215-0036

/Medical

10a. State

Funeral Director

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Completed

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21. Sl

attending physician and for use as the burial-tran After this certification funeral director, p

Examine Physician/Medical ģ Completed Be ဥ Certification:

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attendi within 24 hours are death. To the Funeral Director ≠ completely filled in by the fi

05H-5 State

29b. Signature and title of certifier

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

Cypthen Kuttner-Sand, no

5 ☐ Pending investigation

6 ☐ Could not be

29c. License number D47451

28c. Injury at Work?

1 ☐Yes 2 ☐ No

1 — ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) October 22, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

W.11, amoport, Maryland 21795

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia Kuttner-Vands, no Homewood

28a. Date of Injury (Month, Day, Year)

Nursing Home, 16505 Virginia Avenue

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) OCT 26 2009 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg, N2 0 9

Beatrice Faye Lester Sexamine	3. Time of Death
Secondary Companies As a Facility Name (If not institution, give street and number) 1969 East 01d Philadelphia Road 1969 East 01d Phil	NO LOOCO DM
Funeral Director Pure and Direc	
Director To pure the purpose of the	
Second Part	Birthplace (State or Foreign Country)
The state of Disposition of Funeral Service Licensee Physician (Medical) Figure 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Virginia
The state of Disposition of Funeral Service Licensee Physician (Medical) Figure 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	10d. Inside City Limits
The state of Disposition of Funeral Service Licensee Physician (Medical) Figure 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 ☐ Yes 2 🕅 No
The state of Disposition of Funeral Service Licensee Physician (Medical) Figure 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	d States
The state of Disposition of Funeral Service Licensee Physician (Medical) Figure 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	American Indian, White, etc.
The state of Disposition of Funeral Service Licensee Physician (Medical) Figure 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	White
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician //Medical Physician //Medical Due to (or as a consequence of):	,
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Physician / Medical Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	21921 Approximate Interval Between
Due to (or as a consequence of):	Onset and Death
Examiner	1 9000
Sequentially list conditions, if any, leading 1, immediate cause. Enter Underlying	-
Cause (Disease or injury that initiated events	
Due to (or as a consequence of): Control of the control of the	
- 12 St to 12	
X b	
1 Yes 2 Mo 9 Unknown	Day Year
L E D D Part II Other cignificant conditions contributes to death between	e to the cause of death?
23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 24a. Was an 24b. Were	CProbably 4 ☐ Unknown
1 Yes 2 No 3	e autopsy findings available to completion of cause of
performed? deat 1 Yes 2 No 1	r Yes 2□No
Was case released to frieddal and a season of Death (Check only one) 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (State of Death (Check only one))	Specify)
autopsy performed? 1 Yes 2 No 1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
27. Manner of Death 1 Natural 28d. Describe how injury occurred 1 Natural 2 Describe how injury occurred 1 Natural 2 Describe how injury occurred 28d. Describe how injury occurred	Pural Pauta Number
5 to to to to to to to to to to to to to	
25. Was case referred to medical examiner? 1 Yes 2 No 1 1 1 1 1 1 1 1 1	r as stated. due to the cause(s)
	onth, Day, Year)
0 65902 10/2	2/09
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carlo E. Gopez, N.D. 21921	
State 31. Date filed (Month, Day, Year) 32/ Registrar's Signature Registrar	i i

State of Maryland / Department of Health and Mental Hygien 2009 State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** October 20, 11:00 a M Jesus Lazaro Miranda 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 20820 Severndale Terrace Germantown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours M 2 F 78 Cuba 579-76-7010 June 1, Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10b. County 10a. State 28a-f show ir than "natural", or Items 23a or 28a-f sho The Medical Evaminer must be notified at 1 TYes XX No Director Maryland Montgomery Germantown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20876 20820 Severndale Terrace death v Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ★No 11 Marital Status filed within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify. Cuban White Ves Give Specify þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4or 5+) Maintenance Engineer Property Management 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Thmasa Cabrera Jose Pino Miranda ည other traumatic permit. Pages 1 and 2 shoul Department of Health and Mi Important: If item 27 is mark any Injury or other traumati once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rogelina M. Brown/Daughter 10430 Stallworth Court, Fairfax, VA 22032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2009 Silver Spring, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myocardial Infarction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending f use as IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? 1 □Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1⊈ Yes 2 No Certification: To funeral 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death Director: / d in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 24 hours a Funeral C 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 D20297 October 21, 2009 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4701 Willard Avenue, Chevy Chase, MD 20815 James H. Brodsky, MD 31. Date filed (Month, Day, Year) 82. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

22

State Registrar 31. Date filed-(Month, Day, Year)

29b. Signature and title of certifier

22 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANNA KORZAN

22. Registrar's Signature ach

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D57284

6121 MONTROSE ROAD ROCKVILLE MD 2085

29d. Date signed (Month, Day, Year)

OCT 19 2009

	For State	of Maryland / Dep		, ,		05107			
	Registrar 1. Decedent's Name (First, Middle, Last)	Ce	ertificate of Death		Reg. No 2009	35487			
Physician/	MEGAN ADELE MCNEAL			2. Date of Dea Month	Dav Year	3. Time of Death			
Medical Examiner	4a. Facility Name (if not institution, give street and r	number)	4b. City, Town, or Location	of Death	4c. County of Death	03.83			
	Memorial Hospi	tal	Easton		Talbot				
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday,			9. Birthr	place (State or Foreign			
Director	Usual Residence of Decedent	14 Yrs.		Min. 09/25/1	995 M	RYLAND			
show at	10a. State 10b. County	10c. City, Town or L	ocation		1	0d. Inside City Limits			
Maryle Ba-f : itified	MD TALBOT	EAST	ON			1 ▼ Yes 2 □ No			
a or 2 be no	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cour	ntry?			
leath with the Maryland thems 23a or 23a-f sher must be notified at Funeral Director	21 JUDAS STREET		21601		USA				
r deat	Armed	Forces?	. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica	rigin? (Specify Yes or No- ın, Puerto Rican, etc.)	14. Race - Americ Black, White,				
036 safter or ral", or Examin	If Yes,	es 2 X No Give · Dates.	1 Yes 2 No Specify	r:	Specify: WHI	re			
21215-0036 21215-0036 within 72 hours after giene. ier than "natural", o t, the Medical Exami completed by	15. Decedent's Education (Specify only highest grade complet	16a. Dec	edent's Usual Occupation e kind of work done during mos	at at wasting	16b. Kind of Business Inc	dustry			
S T Z hin 72 hin	Elementary/Seconday (0-12) College	e (1-4 or 5+)	DO NOT use retired)	st or working					
d 2-d 2-d 2-d 2-d 2-d 2-d 2-d 2-d 2-d 2-	17. Father's Name (First, Middle, Last)	0	STUDENT		MIDDLE S	CHOOL			
Be file ental Yead of ic eve	TIMOTHY ERIC MCNEAL		1	ner's Name <i>(First, Middle, N</i> TTY ANN RIDE	•				
A ary	19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Street and Numb	er or Rural Route Number,	City or Town, State, Zip (Code)			
nd 2 s eaith a maz i ier tra	TIMOTHY E. McNEAL/FATH	ER 21	JUDAS STREET	, EASTON, MD	21601				
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from the second sec	20b. Place of Dispose cemetery, cre	oosition (Name of ematory or other place)	Date	20c. Location - City or To	wn, State			
Itim trant:	4 Donation 5 Other (Specify)	SPRING 1		10/21/2009	EASTON,	MD			
Ball permit Depar Impor any in	21. Signature of Funeral Service Licensee) 1	22. Name and Address of Facili FELLOWS, HELFE		IAM FUNERAL	HOME, P.A.			
	23a. Part 1. Enter the disease, or complications the	at caused the death. Do not en							
Physician/	Immediate Cause (Final	each line.		G 20 W		Interval Between Onset and Death			
Medical	disease or condition resulting in death) aa.	to (or as a cons uence of):	ircoma - Me	tastatic		1			
Examiner	Sequentially list conditions, b. ———					109-10/09			
sit mine	cause. Enter Underlying	to (or as a consequence of):							
vecuted 1 and 11-fransit Examiner	Cause (Disease or iinjury that initiated events c Due	to (or as a consequence of):	or as a consequence of):						
760 cate be executed physician and s the burial-transit	L _d								
3760 ificate b ificate b as the b	IF FEMALE:								
ox 687 eath certifice attending p I for use as:	23b. Was decedent pregnant 23c. If yes,	outcome of pregnancy ve Birth 2 Petal death 3	Ectopic pregnancy		23d. Date of delive	ery			
O. Box 68' to the death certification to the attending stacked for use as Physician/M	1 Ves 2 No 4 Pi		Other (specify)		Month	Day Year			
ords, P.O. B requires that the de been signed by the should be detached	Part II. Other significant conditions contributing to	o death but not resulting in the	underlying cause given in Part	I. 23e. Did tob	pacco use contribute to the	e cause of death?			
S, F Lires the sign of be	Left lung collapse due +	s bunchal com	Wessiar	1 🗆 Ye	es 2 No 3 Prot	oably 4 🗆 Unknown			
ord			•	24a. Was ar		osy findings available			
of Vital Records, P. Physician: The law requires the ribis certificate has been signed and director, page 2 should be degree or To Be Completed by				autops perforr	med? death?	mpletion of cause of			
tal	25. Was case referred to medical examiner?			ath (Check only one)	2 100				
f Vi Physic this c al dire		Inpatient 2 ER/Outpatiente of injury 28b. Time of		ursing Home 5 Reside					
nding Figure 1. After the cate		te of injury onth, Day, Year) 28b. Time of injury	of 28c. Injury at work? M 1 ☐ Yes 2 ☐	1	w injury occurred				
Division of Vital Records, tal or Attending Physician: The law requires rs after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be to be the funeral director. Be Completed in Certificate: To Be Completed in Certificates.	3 Suicide 6 Could not be	ce of Injury - At home, farm, st		28f. Location (Str	reet and Number or Rural	Route Number,			
Div tal or ins after al Dir led in	Bul	llding, etc. (Specify)		City or Town					
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certificate: To Be Completed by Physician/Medical Exam	29a. Certifier 1 Certifying Physician: To the (Check 2 Medical Examiner: On the latest terms of the control of	pasis of examination and/or inve	stigation, in my coinion, death o	ocurred at the time, date an	diplace and due to the car	ise(s) and manner stated			
o the vithin 2 the omple	only one) 3 Certifying Nurse Practione 29b. Signature and title of certifier	er: To the best of my knowledge,	death occurred at the time, date	e and place, and due to the	cause(s) and manner as sta	ated.			
0484) () Kh m	^	053299		0 - 16				
	30. Name and address of person whe completed ca	ause of death (Item 23a) (Type.			slane				
pha H	Denise	= Kyle Mo	Print) GOG DI East	n MD	alleol				
State Registrar	31. Date filed (Month, Pay, Year) 9 2009 32	registrar's Signature	back	,					

State of Maryland / Department of Health and Mental Hygiens For State Registrar 35488 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 13, Charles Mumaw October | 2009 **1942 hrs**^M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mt. Airy Kline Hospice House Frederick 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 219-14-8370 1 € M 2 ☐ F 85 June 6, Yrs 1924 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Yes 2 □ No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21702 USA 120 Burgess Hill Way 23a Funeral items ; 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Affiled Folces 1 ∰Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No Specify: white ģ Specify: 3 XWidowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) AZ7 is marked other than "r. y traumatic event Elementary/Secondary (0-12) College (1-4or 5+) National Institutes of Quality Assurance Manager 12 Health 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Coulter Alpha C. Mumaw ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8003 Dustin Drive, Frederick, Maryland 21701 Janice Crabbs - daughter permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once. 20a. Method of Disposition Date 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10-19-2009 Stauffer Crematory Frederick, Maryland 4 ☐ Donation _ 5 ☐ Other (Specify) 21. Signal of Funeral Service Libensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland amile 21702 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** OHN disease or condition resulting in death) /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15+1 300 W. 9th Street, Frederick, Maryland Robert L. Kaufmann, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State varke 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 18, 2009 Physician Middleton Pierce 10:54pm^M Canon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Sykesville Fairhaven Health Care Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) MD 8. Date of Birth Jan 4, 1916 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 11√2 M 2□ F 93 Director 228-40-3862 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County show r than "natural", or items 23a or 28a-f shov the Modeal Exercities must be notified at Sykesville Carroll 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21784 7200 Third Avenue Department of Health and Mental Hydene.
Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Marked other. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify. Completed by WWII 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Clergy Episcopal Priest 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Middleton Olive India Lewis ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Pamela Drumm (Executrix) 21 Brainard Avenue Great Barrington, MA 01230 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 10/19/2009 Sykesville, MD All County Cremation 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee HAIGHT FUNEKAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** onsestive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner signed by the attending physician and I be detached for use as the burlal-transit The law requires that the death certificate be executed Coronary O Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 2.☐No 3 Probably 4 Unknown 1 ☐ Yes s been si should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed' certificate 2 No 2 🗆 No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 21/No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 Tes 2 🗌 No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title October 19 2009 MJL 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hersburg MD 21784 1645 /1am la 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

State Registrar

19

1604 MARKET ST

POCOMOKE CITY MD 21851.

SATYAL,

31. Date filed (Month Hay Yeg) 2

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month October 0 2009 2038 pMMiriam Sarah Malin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b City Town or Location of Death 4c. County of Death Rising Sun Ceci1 Calvert Manor Health Care Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland Days Hours Months SEPT, 2ay, Year 917 Director 219-14-1888 92 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Maryland Ceci1 E1kton ö 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21921 United States 6055 Telegraph Road items after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Deceden Armed Forces?

1 ☐ Yes 2 🛣 No Black, White, etc. than "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Insurance Adjuster Aerospace Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ပ A. Clifford Chidester, Sr. Lillian Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Doreen Smith/Granddaughter 12 Bluemoon Court, Elkton, MD 21921 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Head of Christiana 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State October 0 4 ☐ Donation 5 ☐ Other (Specify) 2009 30. Newark, DE 21. Signature of Funeral Service Licensee Hicks Home for Funerals, any 103 W. Stockton 21921 Street, Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last nding physician use as the burial Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No ō Month Year Pregnant at time of death Day been signed by the a should be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Š Division of Vital Records, or Attending Physician; The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After this funeral of 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending work 1 hours after death. uneral Director: Aft ed filled in by the fur 1 Tyes 2 No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor

To the Fune

completed fi (Check 2 Medical Examiner: On the basis of examination arrow investigation, it may opinion, used to suite, said the sine, said to suite, said the said and place, and due to the cause(s) and manner as state.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state. only one 29b. Signature d title of certifier 29c. License number 29d. Date signed (Month, ay, Year)

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

12

ame and address of person who completed cause of death (Item

32. Registrar's Signature

			For State Registrar		St	ate of I	Maryla	and / Dep <i>Ce</i>	artmen ertificat	t of F e of i	lealth : Death	and M	1ental H	lygie: Reg.	200	9	354	92
		. 1	1. Decedent's Nam	e (First, Mide	die, Last)								2. Date of Month		Day Y	ear	3. Time of	Death
	Physici /Medic		Bernice	Leona	Nalley								Octobe			ear	10:10 a	М
	Examin		4a. Facility Name (lf not instituti	on, give stree	t and numb	er)		4b. City,	Town, or	Location	of Death		- 1	4c. County of	Death		
4			9204 Wende						Silver						Mor	itgon		
	Funeral		 Social Security N 579–12–349 		6. Sex		Age (In y	rs. last birthda 88 Yrs.	/) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month, Nov. 6	Birth Day, Ye	ar) 9	Coun		
	Director		Usual Residence o					88 Yrs.					Nov. 6	, 192	20	Wash	ington,	DC
	land		10a. State	10b. Count	у		10c.	City, Town or I	ocation							10	d. Inside Ci	ty Limits
	h the Maryland or 28a-f show chettined at	ρ	Maryland	Mo	ntgomery	7		Silver S	orina								1 □Yes	2 K No
	the 28a	rec	10e. Street and Nu		<u>-</u>				10f. Zip	Code				10g.	Citizen of Wha	at Count	try?	
	± 5 ±	Funeral Director	9204 Wer	dell St	reet				2	0901				US	SA.			
	ter death	ner	11. Marital Status			/as Decede		U.S. 13	. Was Dece	dent of H	ispanic Ori	igin? (Sp	ecify Yes or Rican, etc.)	No-	14. Race -	America	an Indian,	
9	urs after death v al", or items 236 Examinar i. ust		1 Never Marr	ied 2□ Ma	rried 1	rmed Force							Hican, etc.)			White, e		
03	al", c	by	3 K Widowed	4 Divorce	d If	Yes, Give e ar or Date	es:		1 ☐ Yes	2 K No	Specify:				Specify: V	hite	•	
5-0	n 72 hours af "natural", or	Completed by	(Spe	15. Decede	ent's Education est grade con	n onleted)			edent's Usua e kind of wo			t of work	ina	16b	. Kind of Busir	ess/Ind	lustry	
21	within lene. than "	dr.	Elementary/Seco			ollege (1-4	or 5+)	life.	DO NOT us	se retired	1)	. 0, 1, 0, 1,	119					
2	led w lygiel her th	ខ						H	omemake:	r	10.11.11		/F: 4 A .: 1	7		Home	:	
ano	be fill	Be	17. Father's Name Walter L.												len Surname)			
7/8	ould d Mer narke	은						1					L. Wilk					
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hc to f Health and Mental Hygiene. If item 27 is marked other than "natun or other traumatic event, it. M. dical		19a. Informant's N			rint)									ty or Town, Sta	ate, Zip	Code)	
6,	l and lealt im 27		James P.		Son		001						g, MD 2		Lassian Oil		01-1-	
0	ges It of H If ite or of		20a. Method of Dis 1 Burial 2	•	3 ☐ Remov	val from Sta	ire i	. Place of Disp cemetery, cr				Oct.	Date 26,	200	Location - Cit	y or To	wn, State	
ţ	t. Pa tmer tant: jury		4 ☐ Donation				G	ate of He			- 1	2009	•		ver Spri	ng,M	aryland	!
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra once.		21. Signature of Fu	uneral Servic	e Licensee	gla .			Prane ar Francis 500 Uni	d Addres J. (vers	s of Facilit Collin ity Bl	s Fundada	eral Ho	me In er Sp	c. ring, MD	209	01	
			23a. Part 1. Emer t shock, or hea	he disease, dart failure. Lis	or complication	ns that caus	sed the de h line.	eath. Do not e	nter the mod	le of dyin	g, such as	cardiac	or respirator	y arrest,			Approximate Interval Bet	ween
4	Physician	Ì	Immediate Cause disease or condition	òn	A	cute M	yocard	dial Infa	rction								Onset and I	Jeath
	/Medical		resulting in death)															
	Examiner		Sequentially list co	nditions.	b													
0	ait ad	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	mediate	,	Due to (or	as e cons	equence of):								4		
P	and trans	Kam	that initiated events resulting in death)	5	c	Due to for		equence of):										
8760,	be e) ician ourial	Ē	, , ,			Due to (or	as a cons	equence on:										
87	icate be executed physician and the burial-transit	dical			d													
9 ×	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE:		23c If	yes, outcor	me of pred	nancy										
Box	atten for us	ian	23b. Was deceden in the past 12	months?	1	Live birt Pregnar	h 2 🗆 Fe	etal death 3	☐ Ectopic p		у				23d. Date of Month		•	/ear
O.	that the de ned by the a detached t	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown			Unknow		or death 5	Other (sp	еспу)				-				
σ.	that t ed by detac		Part II. Other signi	ficant condi	tions contribut	ting to deat	h but not r	esulting in the	underlvina c	ause give	en in Part I		23e. Di	d tobacc	o use contribu	ite to th	e cause of d	eath?
Records,	signed be det	Completed by						3	, ,	3			1	Yes	2 No 3] Prob	ablv 4.¥⊓l	Jnknown
Š	w requir s been s should l	etec		·														
3e	elaw has je 2 s	ם	-										24a. W	topsv	24b. Wei prio dea	re autor	osy findings npletion of c	available ause of
	iclan: The certificate ector, pag												1 □ Yes	rformed s 2	No 1 🗆		2 □ N o	
V.	Physician: r this certificaral director, p	Be	25. Was case refer examiner?		al Hospit	al:				Othe			n (Check onl					
of	Phys this ral dii	£	1 ☐ Yes 2 🔀			a. Date of I		ER/Outpati		/A	4 1 190				6 □Other	(Specify)	
n	ding F h. After funera	io	1 X Natural	5 Pend		(Month,	Day, Year)	Injury	M	8c. Injur Work	yan (? Yes 2□	- 1	280. Describ	e now ir	ijury occurred			
Si	Attending or death. ector: After by the fune	ical	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could	not be	e Place of	Injuny - At	home, farm, s			168 2 🖂		20f Location	. (Cton at	and Number	O	Doute Muse	has
Division of Vital	after death. Director: A	Certification: To	4 ☐ Homicide	deter	mined 20	building,	etc. (Spe	cify)	ireet, lactory	, onice			City or	Town, St	ate)	Ji nuiai	noute Ivani	ber,
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Euneral Director: After this certificate h completely filled in by the funeral director, page		29a. Certifier	1X Certify	ing Physician	a: To the he	est of my k	nowledne dea	th occurred	at the tir	ne date ar	nd place	and due to t	ho caus	e(s) and mann	or ac cl	tated	
	Hos 24 h Fur Fur etely	Medical	(Check only one)	2 Medica	I Examiner: (On the basi	s of exam	ination and/or	nvestigation	, in my o	pinion, dea	ath occur	red at the tim	ne, date	and place, and	due to	the cause(s)
	othic othic ompl	Me	29b. Signature and	title of certif			- (290	. License	e number			29d.	Date signed (A	Aonth, L	Day, Year)	
				/(14	9/	181	30.			I	45471			α	ctobe	er 21,	2009
	20		30. Name and addr	ress of person	n who comple	ted cause of	of death (II	em 23a) (Tune	Print)									
			Yeheysi:		/ /			g Street		r Snr	ring N	מחלים	210					
	Sta	te	31. Date filed (Mon			32 Regi	istrar's Sig	nature	, OTIVE	- obr	шу, I	w 205	,10					
	Registr		01	CT 22	2009	Denn	w	nature A	week.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. Na 2009 35493 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 8 **Physician** 1230 PM 2009 ctober MARY ELLEN NIXON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Easton Talbot EASTON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🕱 F 69 Director AUG. 20,1940 MARYLAND 218-38-4659 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State show traumatic event, the Medical Evaminer must be notified at Director 1 TYYes 2 □ No 28a-f MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Items 23a UNITED STATES 29770 LYONS DRIVE Funeral 21601 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 ò 1 ☐ Yes 2 🕱 No Specify: Specify: WHITE <u></u> 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY MEDICAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROLAND SPICER ၉ MARGARET SAMPSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. NANCY L. TURNER/COUSIN 10613 TOPSFIELD DR. COCKEYSVILLE, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State NEW FREEDOM 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OCT. 28,2009 NEW FREEDOM, PA CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** line disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner executed burial-trans resulting in death) Last attending physician for use as the buria Box 68760, law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) P.O. the i detached g Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Watural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ca (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

TLS 10

> State Registrar

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Year)

2/2

			For State Registrar		State of	Marylan		artment of F rtificate of		and Me	-	giene Reg. No 20	09	35	495
	Physici	an	1. Decedent's Name (F	irst, Middle, La	,		0-4			2	. Date of De Month	ath Day	Year	3. Time o	
-	/Medio	al	Mina 4a. Facility Name (If no	t institution, giv	R.		Oates	4b. City, Town, o	r Location o	of Death	10	4c. County	of Death	214	.5 "
- part	LAdiiii	CI		-	al Campu			Ciu	mber	land	t	Alla	ean)	J	
	Funeral Director		 Social Security Number 191-24-21 		Sex 7. □ M 2 □ x F	Age (In yrs. 86	last birthday) Yrs.	If Under 1 Year Months Days	Hours	24 Hrs. 8 Min.	Date of Birn (Month, Da Dec 6	, 1922	-9. Birthp Coun	ace (State try) OH	or Foreign
	w w		Usual Residence of De 10a. State 10	cedent b. County			y, Town or Lo	cation						Od. Inside C	City Limits
	the Marylar 28a-f show	ctor	MD	Alleg	any	100.00		mberland							2 □ No
	with the	Director	10e. Street and Numbe		Stroot St	۱۸/		10f. Zip Code	215	02		10g. Citizen of	What Coun	try?	
	ms 23	Funeral	13701 D	owning	Street, S'	ent Ever in U.	S. 13.	Was Decedent of H			fy Yes or No		ce - Americ		
920	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Eventhar must be notified at	þ	1 ☐ Never Married 3 ☐ Widowed 4 ☐		Armed Force 1 Yes 2 If Yes, Give Year or Date	□ No \AAA		1 ∐Yes, specify Cub 1 ∐Yes 2 ☑No	an, Mexican Specify:	i, Puerto Ri	can, etc.)	Specif	ck, White, e	nite	
2-0	72 ho "natur	eted	15 (Specify	Decedent's Econly highest gra	ducation ade completed)		(Give	dent's Usual Occup	durina most	of working		16b. Kind of B	usiness/Ind	lustry	
2121	filed within Hygiene. other than "	Completed	Elementary/Seconda	7y (0-12)	College (1-4	or 5+) 2+		DO NOT use retired istered Nu	,			Hopsi	tal		
Maryland 21215-0036	should be filed nd Mental Hygi marked other imatic event,	Be	17. Father's Name (First	st, Middle, Last nce Har								Maiden Surnan			
aryle	0) = 40 3	ျ	19a. Informant's Name	/Relationship (Type. Print)		19b. Mailir	ng Address (Street						Code)	
	12 # Z		Charles		h	usband	1	ng Address (Street 5701 Dowl	ning S						502
Baltimore,	Pages nent of ant: If it any or c		20a. Method of Disposi 1 Burial 2 C 4 Donation 5 D	remation 3 [יווי	. 0	cky Gap	sition (Name of matory or other place) Veterans (Cemete	• •	11/2/2009	Flints	stone	wn, State	MD
Ball	permit. Departr Importa any Inju		21. Signature of Funer	al Service Licer	ree	7	22	2. Name and Addre Scarp 108 V				and, MD 2	1502		_
	flicate be executed Medical Examiner s the burial-transit	dical Examiner	23a Part 1. Enter the canon shock, or heart ta Immediate C7 se (Findisease or cyndition resulting in eath) Sequentially list condition any, leading to immediate Cause. Enter Underlying Cause (Disease or injust that initiated events resulting in death) Last	ons, flate ig	Due to (or b. Due to (or c.	as a consequence as a c	uence of):	CARC	(NOM	A (COL	0N ·		Approxima Interval Be Onset and 7	Death
.O. Box 68	requires that the death certificate be executed been signed by the attending physician and hould be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 ☐ Yes 2 ☐ Nor 9 ☐ Unknown	nths?		th 2 ☐ Feta nt at time of c	Ideath 3	☐ Ectopic pregnanc ☐ Other (specify) _	у .				ate of deliver	ry Day	Year
ls, P.	w requires that s been signed b should be deta	ρ	Part II. Other significal	nt conditions	contributing to deat	h but not res	ulting in the u	nderlying cause giv	en in Part I.			obacco use con res 2 ⊡*Ño		e cause of	
cor	> 11 0	leted									24a. Was			osy findings	
<u> </u>	The la ate ha page 2	Completed						· · · · · · · · · · · · · · · · ·			autop perfo 1 □ Yes	rmed? 2 PNo	prior to con death?	npletion of a 2 ⊠No	cause of
E	di S	To Be	25. Was case referred examiner? 1 ☐ Yes 2 ☐ No	to medical	Hospital:	atient 2 🗆	ER/Outpatier	nt 3 DOA Oth	or:		Check only o	<i>ne)</i> dence 6 ☐Oth	ner (Specif	/)	
0 0	Ing After	on: T	27. Manner of Death 1 ✓ Natural 5	Pending		Injury Day, Year)	28b. Time of Injury	Wor	y at k?	28		now injury occur		<u> </u>	
	e Hospital or Attending n 24 hours after death. le Funeral Director: After pletely filled in by the fune	Certification:	2 ☐ Accident 3 ☐ Suicide 6 4 ☐ Homicide	investigation Could not b determined		Injury - At ho , etc. <i>(Specif</i>	ome, farm, str y)	M 1 □ eet, factory, office	Yes 2□N		f. Location (S City or Tox	Street and Numb vn, State)	ber or Rura	Route Nur	mber,
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier 1/2 (Check only one)	Certifying Ph Medical Exar	niner : On the basi	is of examina	wledge, deat tion and/or in	h occurred at the ti vestigation, in my o	me, date an	d place, an	d due to the at the time,	cause(s) and m	anner as s	tated.	s)
	To the within 2 To the I complet	Medical	29b. Signature and title	ocertifier	and manner	stated.		29c, Licens	e number			29d. Date signe	d (Month,	Day, Year)	
			> \(\)	1		1/		D2	337	11		Octobe	ex 28	7,20	209
			30. Name and address	. 7	901	of death (Item	23a) (Type,	Print) Drive 5	SL ~	. 2	A 1.	21	1 84		1507
	Sta	te	31. Date filed (Month, L	Day, Year)			ture	harden.	JE. O	(0)	umb	revian	a, M	V. L	1302
	Registr	ar		AUADA	LUUD A	مسائلاتنانية	13. 61	Basker							

3

		1 - State of Maryland / De State of Maryland	epartment of Health and N Certificate of Death	Mental Hygiene Reg. No.	2009 35496
Phys /Me	ician	1. Decedent's Name (First, Middle, Last) Virginia Odell Pedone		2. Date of Death Month Day October 20, 2	3. Time of Death 7:20 p
- Exam		4a. Facility Name (If not institution, give street and number) Montgomery Hospice—Casey House	4b. City, Town, or Location of Death		County of Death Montgomery
Funer Direct		5. Social Security Number 408–32–5416 6. Sex 1 □ M 2 F 7. Age (In yrs. last birtho	Months Davs Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 6, 1924	9. Birthplace (State or Foreign Country) Virginia
the Maryland 28a-f show	Director	Usual Residence of Decedent 10a. State	r Location Kensington 10f. Zip Code	10g Citiz	10d. Inside City Limits 1 □ Yes 2 □ 4No en of What Country?
h with 23a or	a Di	5014 Flanders Avenue	20895	US	·
DallIMOre, INIBITYIANG ZIZIS-UU3O permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm. Indical Experiment with be notified at	d by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:		4. Race - American Indian, Black, White, etc. Specify: White
vithin 72 h jiene. r than "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12	ecedent's Usual Occupation live kind of work done during most of work fe. DO NOT use retired) Manager	king 16b. Kin	d of Business/Industry Phone Company
and a be filed antal Hyg ced other c event,	BeC	17. Father's Name (First, Middle, Last) Julius William Lipscomb		ne (First, Middle, Maiden S	Surname)
Maryland ZIZI: 2 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r traumatic event, Im. Med	2	19a. Informant's Name/Relationship (Type. Print) 19b. M	ailing Address (Street and Number or Rui	ral Route Number, City or	Town, State, Zip Code)
Pages 1 and 2 nent of Health is ant: If Item 27 is ury or other tra		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State	crematory or other place)		ation - City or Town, State
DAILLINOT DESTRUCTION DESTRUCT	ņ	4 □ Donation 5 □ Other (Specify) Parklaw 21. Signature of Funeral Service Licensee		2009 Rock	cville, Maryland
a m Ge o	once	23a. Part 1. En ur the disease, or complications that caus. The death. Do not	500 University Blvd. W.	, Silver Spring	g, MD 20901 Approximate
Cate be executed with the burial-transit the burial-transit	al	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last			Onset and Death
BOX of auth certification attending of for use as	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23	3d. Date of delivery Month Day Year
v requires that been signed b	by P	Part II. Other significant conditions contributing to death but not resulting in the Cerebrovascular Accident	e underlying cause given in Part I.		e contribute to the cause of death? No 3 Probably 4 Minknown
ar neco n: The law red ficate has bee r, page 2 shor	Completed			24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be	25. Was case referred to medical examiner? 1	atient 3 DOA Other: 4 Nursing Hore of Work? M 1 Yes 2 No	28d. Describe how injury	occurred Number or Rural Route Number,
Hospital 24 hours a Funeral a	ledical Ce	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, d (Check only one) 2 Medical Examiner: On the basis of examination and/c and manner stated.			
To the within To the comple	Med	29b. Signature and title of certifier J. Www.chou, MD	29c. License number		signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Tyl Jocelyne Kouatchou, MD 1355 Piccard Driv	pe, Print) re, Rockville, MD 20855		
Regi	State strar	31. Date filed (Month, Day, Year)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 2009 Janet Campana Papini October 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 M 2 TX 65 September 6, 1944 Connecticut 040-36-6490 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐Yes 2 No Maryland Frederick Frederick 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21701 USA 2250 Bear Den Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify. white Specify: 3 → Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Pharmacist Technician Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mae Kennedy Leroy Campana 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21701 2442 Merchant Street, Frederick, Maryland Cathryn Landry - sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 10-19-2009 Stauffer Crematory Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signa ure of Funeral Serv 1621 Opossumtown Pike, Frederick, Marylad 21702 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COPD Due to (or as a consequence of) lun9 Due to (or as a consequence of) Due to (or as a consequence of) 23d. Date of delivery réath 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify)

Physician /Medical **Examiner**

> as attending

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nas page cate

within 24 hours area To the Funeral Director: Aft

Medical

requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

Hospital or Attending Physician:

Physician

/Medical

Examiner

Funeral

Director

show

28a-f

items 23a

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Health a

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death

filed within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

traumatic event, the Middowl Examiner must be notified at

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-trans

Physician/Medical IF E 23b. þ Completed 25. Was case referred to medical Be Certification: To

	d
EMALE: Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	1 ☐ Yes 2 ☐]No 3□ Pro	bably 4 Unknown
	24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	24b. Were autoprior to codeath? 1 □ Yes	opsy findings available ompletion of cause of 2 No
26. Place of Death (Check only one)		

examiner? 1 ☐ Yes 2 ☑ No	Hos
27. Manner of Death	
1 Natural 5 Pending	
2 ☐ Accident investigation	1

3 Suicide

1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

28b. Time of 28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office

Other: 4 \(\text{Nursing Home} \) 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

4 ☐ Homicide	dotominod	building, etc. (Specify)	City or Town, State)
9a. Certifier		fian: To the best of my knowledge, death occurred at the time, date and pla	
(Check only one)	2 ☐ Medical Examine	r: On the basis of examination and/or investigation, in my opinion, death or and manner stated.	curred at the time, date and place, and due to the cause(s)

9b.	Signature and title of certifier	
	Shan	

ı	29c. License number
	PIMALOL DO
ı	1117674010
L	0.770

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

32. Registrar's Signature

ORIGINAL

1. Decedent's Name (First, Middle, Last)

VERLEAN

Physician

/Medical

POWELL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Rec. No. 2

2. Date of Death

OCTOBER

3. Time of Death

2:00 AM

2000

DHMH 17 Rev 1/2001

State

Registrar

Nodehzda

OCT 20 2009

31. Date filed (Month, Day, Year)

09-08349 Marc Charles Paugh

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar	e of Marylana / D	Certificate of				eg. No.	
Physicia Medical Examin	ın/	 Decedent's Name (First, Middle, I 					2. Date of Deat Month	Day Year	3. Time of Death 0639 hrs
vieuicai Examii		Marc Charles 4a. Facility Name (if not institution,			4b. City, Town, o	r Location of De	October 28	4c. County of De	
		7286 Jake Street	,		Willards			Somerset	Wicomico
Funeral		5. Social Security Number 6	. Sex 7. Age (In	yrs. last birthday)	If Under 1 Ye		Hrs. 8. Date of Bir		Birthplace (State or Foreign Country)
Director		217-11-7703	1XM 2 F 25	Y	rs. Months Da	ys Hours	6/29/		MD
any	-	Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Loc	ation				10d. Inside City Limits
. ₫		MD Wicom	ico	Willards					1 Yes 2 XNo
Maryland 28a-f show d at once.	Director	10e. Street and Number			10f. Zip Code		11	0g. Citizen of What C	Country?
the M		7286 Jake St.			2187	74		USA	
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once.	Funeral	11. Marital Status 1 XNever Married 2 Marr	12. Was Decedent Ever	.if	Vas Decedent of H Yes, specify Cuba		(Specify Yes or No erto Rican, etc.)	- 14. Race - Ar White, etc	nerican Indian, Black, c.
한 등리			1 Yes 2 X	No 1	Yes 2 X N	o specify:		Specify: N	white
ours af atural	d b	15. Decedent's Education (Specif	or Dates:	ted) 16a. Deced	ent's Usual Occupa	ation (Give kind		16b. Kind of Busine	
5-0036 led within 72 hours afte ftygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			e. DO NOT use	relied)	, , , , , , , , , , , , , , , , , , , ,	
15-003(filed within I Hygiene. Id other tha	E	12 17. Father's Name (First, Middle, L	ast)	n/s	d	18.Mother's N	lame (First, Middle, I	n/a Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Harry Carl Pa	·			Mar	y Colleen	Council	
ID 21 should and Me 17 is man	٢	19a. Informant's Name/Relationship			·			mber, City or Town, S	
e, MD I and 2 shu Health and item 27 is	1	Mary Paugh / 1 20a. Method of Disposition	notner	20b. Place of Disp			Parsonsbu Date	rg, MD 218	y or Town, State
- ← = 0		1 Burial 2 XCremation		crematory or Cape Hei		cem.	11/2/2009	Frankfor	rd. DE
Baltimo permit. Pagee Department o Important:	1	4 Donation 5 Other Spe 21. Signature of Funeral Service Li			. Name and Addre			Funeral H	
Dept Inji		(Jegora /)	MSW		108 Wil	liam St	., Berlin	, MD 21811	
Physician /Medical		23a. Part I. Enter the disease, or co failure. List only one cause of	n each line.					est, shock, or heart	Approximate Interval Between Onset and Death
caminer		Immediate Cause (Final disease or condition resulting in death)	a. Hypertensi		ovascular	disea	se		Dean
		Sequentially list conditions,	b						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseque	ence of):					
ed Isi	Exan	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):			•		
executed an and al - transit		X UNPENDED	X AMENDED 23a,	PII,27,pe	rmE, g89	8 12/10	0/09 TT		
760, icate be exe physician a	Medical	IF FEMALE:	23c. If yes, outcome o		090 12/4	709 11		23d. Date of del	
ox 687 eath certific	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time		Fetal death 3 Other (Specify)	Ectopic p	regnancy	Month	Day Year
Box 68760, e death certificate b the attending physical for use as the but	Physician	1 Yes 2 No 9 Unkn		5	Other (Specify)				
P.O. ss that the gned by the detache	by PI	Part II. Other significant condition	•	it not resulting in th	e underlying cause	e given in Part			e to the cause of death? Probably 4 Unknown
S, P quires t	ted t	Morbid obesit	-У			 			re autopsy findings available
cords, law requir has been s	Completed						auto perfo	psy prior deal	r to completion of cause of th?
tal Rec rian: The l certificate l ector, page		25. Was case referred to medical			26 Pla	ce of Death (C		2 No 1	Yes 2 No
Vital ysician his cert directo	Be c	examiner?	Hospital: 1 Inpatient	2 ER/Outpatie		(Othor:	lursing Home 5	Residence 6 🗸	Other: Scene
ing Phyling Phy After tl funeral	n: To	27. Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Time		jury at Work?		how injury occurred	
sion trendi death. ctor:	atio	1 X Natural 5 Pendir 2 Accident Investi	igation			Yes 2 N			2 12 1 1 1 2
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should b	Certification:	detern	not be nined (Specify)	- At home, farm, s	treet, factory, office	e building, etc.	or Town,		or Rural Route Number, City
Hospit 4 hour Funera	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						stated.		
To the I within 2 To the I							to the cause(s)		
29c. License number 29d. Date signed ((Month, Day, Year)			
October 29, 2009									
_		30. Name and address of person v Laron Locke MD. As	vho completed cause of deat sistant Medical Exam		nn Street, Bal	timore, MD	21201		
S	ate	31. Date filed (Month, Car, Year)			harri				
Regis	trar	00130	2009 Clerana	J 14. 14	Merca				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 35500 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 19, 2009 7:05 P M JAMES PORTER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE"S DISTRICT HEIGHTS 2116 TIBER DRIVE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Hours Min. 11/15/1940 RockyMt., NC Director 68 <u> 243–56–9485</u> Usual Residence of Decedent 10b. County within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No District Heights Marvland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2116 Tiber Drive 20747 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 Never Married 2 X Married Completed by Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 7's ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Printer Processor Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hattie Howard Elijah Porter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Porter / Wife 2116 Tiber Drive District Heights, Maryland 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 10/23/2009 Inez, North Carolina Stephen Baptist 21. Signal re of Funeral Service Licen 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 3401082 23a. Part 1. Erfer the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5538 MARLBORO PIKE FORESTVILLE, MARYLAND 20747 Interval Between Onset and Death Immediate Cause (Final Filysician/ disease or condition resulting in death) Glioblastoma months Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that the death certificate be executed the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. Hospital or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 N certificate 2 🗌 No 1 🗌 Yes 25. Was case referred to medical To Be filled in by the funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**O 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending s after death. 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) PHYSICIAN D53590 OCTOBER 20, 2009 BROADHAM 624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYDNEY 04 MD ROOM 609 31. Date filed (Month, Day, Year, 32. Registrar's-Signature State OCT 2 2 2009

DHMH 17 Rev 7/2009

Registrar